A PILOT STUDY OF THE EFFECTIVENESS OF EMOTIONALLY FOCUSED COUPLE THERAPY

A DISSERTATION SUBMITTED TO THE GRADUATE SCHOOL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

DOCTOR OF COUNSELING PSYCHOLOGY

BY

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MUNCIE, INDIANA

JULY 2019

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Acknowledgements

This work is dedicated to my dear friend and mentor David Davis, who helped me remember who I was and could be. What a rich gift your friendship was to my life.

Many people have been involved in this journey, but it would not have happened without my dissertation chair taking a chance on me and then sticking with me through ups and downs. Much thanks to Dr. Spengler for his guidance and grace along the way, and for inspiring me to be an effective clinician. Thanks to Dr. Nicholas for providing consistent stability and wise input across my time in the program, an anchoring presence that kept me on course at key times during my training experience. Thanks to Dr. Chan for engaging conversations at MCCHC and for providing his expertise to my committee. Thank you to Dr. Hall for his research expertise and valuable feedback.

The ten pieces of my heart that are my family roots have multiplied over my time here. Thanks to Dad, Mom, Julie, Brian, Brad, Mark, Grace, Scott, Kyle, and Kristen for being essential bricks in my foundation and for putting up with my absence so often over these last years. Thank you to all the new additions - Jeremy, Courtney, Noelle, Emily, Kinzie, Tara, Ali, Jair, JD, Jonah, Annalisa, Jordan, Jacob, Judah, Joey, Levi, Cade, Silas, Solomon, Colin, and Theo – each a miraculous joy and bright light in the family kaleidoscope.

Along the way, a host of friends and colleagues enriched the path. Meredith Erwin, thanks for the many years, for joyful enthusiasm, and for not giving up. Thanks to Emily Elder for literally and figuratively walking the graduate school path with me, serving as balance, sounding board, and inspiration. Thanks to Emma Carter for insisting on friendship and for making life so much better with it. Thanks to Cara Lynch, Mandy and Will Johnson, Hanna

DelaGardelle, Andrea Monge, and Kristeena Jenkins for weeping and rejoicing together across our educational endeavors. Special thanks to Manisha Rustagi for being my doc school incubator buddy. Much thanks to "my other families" who housed and fed and inspired me along the way – Robyn, Kayleigh, Mary, and Kevin – whose practical care and love has been invaluable and motivating. Finally, several supervisors contributed to my training and growth: thank you to Dr. McNeany, Dr. Szerlong, Dr. Hayden, Dr. Baker, Dr. Wilson, Dr. Sparks, Dr. Simon, Dr. Anderson, and Dr. Finke. Special thanks to Dr. Erin Davis for seeing me through to the end.

This project could not have happened without the EFT therapists who were wiling to step out and submit their work. That gift and their ongoing dedication to EFT practice are important and appreciated. More so, it could not have happened without couples taking courageous steps to make their relationships better. A great deal of humble thanks is due to my own clients who give me the gift of being part of their personal paths. These people give me courage to move past my own fears for the sake of what could be. Their hope is what compels me to pray, **"*Draw us into your love, Christ Jesus, and deliver us from fear.*"**

A Pilot Study of the Effectiveness of Emotionally Focused Couple Therapy

The actual impact of psychotherapy treatment for the client is arguably the most important focus in psychotherapy research. The manualized treatment model Emotionally Focused Couple Therapy (EFT) (Johnson, 2004) has well-established evidence for efficacy. One of the few empirically validated approaches to treating couple distress (Lebow, Chambers, Christensen, & Johnson, 2012; Lebow, 2018), EFT has broad empirical support from efficacy trials, task analyses, and studies of the effectiveness of the model for specific presenting problems. However, minimal research has been conducted to examine outcomes of EFT in naturally occurring clinical conditions (Kennedy, Johnson, Wiebe, & Tasca, 2017; Weissman et al., 2017; Wittenborn et al., 2018). Evidence for the effect of psychotherapy models under natural conditions is needed to show the transportability of an established model for use in every day practice with clients who represent the complexity found in naturally occurring clinical samples (Lebow, 2018; Leichsenring, 2004; Sexton et al., 2011). This pilot study investigated the effectiveness of EFT under naturalistic conditions by collecting outcomes from therapists in their every day practice. After defining the terms *efficacy* and *effectiveness*, the body of EFT research is reviewed within the context of Sexton and colleagues' (2011) framework for categories of evidence, and methods for conducting the current effectiveness study are described (for a comprehensive review of relevant literature, see Appendix A).

Efficacy and Effectiveness

The American Psychological Association Presidential Task Force on Evidence-Based Practice defines efficacy as "evaluation of the strength of evidence pertaining to establishing causal relationships between interventions and disorders under treatment" (2006, p. 272). Effectiveness is defined as "studies of interventions as they are delivered in naturalistic settings"

(2006, p. 274). Randomized controlled trials (RCTs) have been given primacy within the evidence-based environment because they are seen as giving credibility to the approach, while the transportability of laboratory evidence to real world applications has been assumed (Lebow et al., 2012; Leichsenring, 2004; Sexton et al., 2011). As psychotherapy research has progressed, increased attention has been given to effectiveness research as a converging source of evidence with studies of efficacy and client/therapist variables.

Parallel to the rest of the field, couple therapy research has tended towards emphasizing efficacy to establish legitimacy in the field, and poor clinical representativeness is a primary concern of couple therapy outcome research (Lebow et al., 2012). When comparing couple therapy RCT outcomes to effectiveness outcomes, Halford, Pepping and Petch (2016) identify only four effectiveness studies that have directly evaluated change in relationship adjustment in routine community practice (Doss et al., 2012; Hahlweg & Klann, 1997; Klann, Hahlweg, Baucom, & Kroeger, 2011; Lundblad & Hansson, 2006). More recently three EFT studies have approximated effectiveness methodology (Kennedy et al., 2017; Weissman et al., 2017; Wittenborn et al., 2018). The scarcity of effectiveness research in couple therapy is a significant deficiency in the evidence for couple therapy treatment.

Effectiveness studies increase the methodological diversity of empirical evidence and provide evidence for the generalizability of clinical trial results (Kazdin, 2008; Sexton et al., 2011). Outcomes collected under naturalistic conditions provide information on the transportability of the model to various settings. Specifically, they provide feedback on whether dissemination, implementation, and sustained adoption of evidence-based models is occurring successfully (McHugh & Barlow, 2010). An appropriate progression of the success of establishing evidence that a treatment works is to assess transportability through clinically

representative studies (Lebow et al., 2012; Sexton et al., 2011).

Naturalistic studies are not just supportive to efficacy studies, but necessary evidence for the outcome of treatments for clinical populations (Leichsenring, 2004). An enduring complaint by practitioners is that the populations and courses of treatment represented in clinical trials do not accurately represent their day-to-day clinical struggles (Leichsenring, 2004; Ollendick, 2014). In 1995, Seligman wrote, "The efficacy study is the wrong method for empirically validating psychotherapy as it is actually done, because it omits too many crucial elements of what is done in the field" (p. 955). Psychotherapy is not a packaged drug and is inherently impacted by interpersonal factors and field adaptations (McHugh & Barlow, 2010). Beyond testing for generalizability of results and the transportability of the model to natural settings, studies that aptly represent the challenges of daily practice are needed (Lebow, 2018). Concerns that tightly controlled trials do not address actual practitioner and patient experiences have persisted (Lebow et al., 2012; Leichsenring, 2004; Sexton et al., 2011), and effectiveness studies seek to address this research-practice gap.

Building on converging levels of evidence for EFT, effectiveness research increases support for the transportability of this couple therapy treatment and provides important information about application of the model in naturalistic settings. The existing body of EFT research has studies across all levels of evidence outlined by Sexton et al. (2011), but only three studies that approximate effectiveness research methodology by assessing outcomes in natural settings (Kennedy et al., 2017; Weissman et al., 2017; Wittenborn et al., 2018). Following a review of the existing research, methods for the present pilot study are discussed.

Levels of Evidence for Emotionally Focused Couple Therapy

EFT is a theoretically grounded, research-based, brief approach to treating couple distress

and healing relationship bonds (Greenman & Johnson, 2013). The model has nine steps and three stages, developed out of theoretical integration of adult attachment, systemic, humanistic, and experiential theories, as well as the model creator's close observation of what did and did not work in couples therapy sessions (Johnson, 2004). The three stages include: cycle de-escalation through tracking interactional patterns and placing them into an attachment framework, restructuring the attachment bond through key change events of withdrawer re-engagement and blamer softening, and consolidation and integration of treatment gains, with practical applications of change to specific problems (Johnson, 2004). Key EFT interventions are detailed in the EFT treatment manual (Johnson, 2004) and have been operationally defined in the Emotionally Focused Therapy Coding Scheme for the purposes of EFT process research (EFT-CS; Bradley, 2001). Systematic training in EFT is overseen by The International Center for Excellence in Emotionally Focused Therapy (ICEEFT; www.iceeft.com). Across the development of the model over the last 30 years, impressive empirical support has also been amassed from over 40 efficacy outcome studies, studies of various client problems, task analyses, process-outcome studies, and meta-analyses.

A number of schemas for levels of psychotherapy evidence have been suggested. For example, Howard and colleagues (1996) delineated three categories of research: (a) Does it work under special, experimental conditions? (e.g., *efficacy*), (b) does it work in practice? (e.g., *effectiveness*) and, (c) is it working for this patient? (e.g., *patient-focused*). Similarly, Sexton et al. (2011) propose a hierarchy of categories of evidence, in which treatments are considered increasingly supported by research as studies within each category are amassed:

Category 1: Absolute efficacy/effectiveness (treatment is effective compared to no-treatment/placebo) and relative efficacy/effectiveness (treatment is as effective or more effective

compared to other competing treatments),

Category 2: Change mechanisms (outcomes are linked to model-specific change mechanisms as theoretically expected), and

Category 3: Contextual efficacy (treatment is shown to have positive outcomes with various populations under various conditions) (Sexton et al., 2011). A brief synopsis of previously published EFT research will be reviewed here using this categorical framework.

Absolute and relative efficacy/effectiveness. Absolute evidence refers to finding reliably improved, clinically relevant outcomes as a result of intervention, compared to a wait-list or no treatment condition, while relative evidence refers to evidence that a treatment works compared to an alternative treatment (Sexton et al., 2011). Several RCT outcome studies of EFT have been conducted with randomly assigned groups for comparison to other treatments and waitlist controls (Wiebe & Johnson, 2016). The first two published studies of EFT are examples of absolute and relative efficacy evidence (Johnson & Greenberg, 1985a; Johnson & Greenberg, 1985b). Johnson & Greenberg (1985a) compared outcomes to a no-treatment, wait-list control group via a within-subjects design where participating couples served as their own wait-list controls. Couples were given measures at four time points, 8 weeks prior to therapy, at the beginning and end of 8 weeks of treatment, and at an 8 week follow up. These findings have been replicated in other comparisons to wait-list controls, conducted by researchers not associated with the creation of the model, with comparable results (Denton, Burleson, Clark, Rodriguez, & Hobbs, 2000). Johnson and Greenberg's (1985b) comparison of EFT to CBT, a problem-solving instruction intervention, and a wait-list group exemplifies relative efficacy. Results indicated better outcomes for the EFT group as measured by the Dyadic Adjustment Scale (DAS) and Personal Assessment of Intimacy in Relationships scale (PAIR). Other studies

have compared EFT to Cognitive Marital Therapy (Dandeneau & Johnson, 1994), to Integrated Systemic Therapy (Goldman & Greenberg, 1992), and EFT as usual compared to EFT with a communication-training component added (James, 1991). EFT has better outcomes than no-treatment controls, and at least equivalent outcomes to comparison treatments.

Long-term follow-up studies at two and three years show maintenance of therapeutic gains (Clothier, Manion, Gordon-Walker, & Johnson, 2002; Halchuk, Makinen, & Johnson, 2010; Wiebe et al., 2017). Comparable to other couple therapy approaches, such as Integrative Behavioral Couple Therapy (IBCT) (Christensen, Atkins, Baucom, & Yi, 2010), assessment of long-term gains finds that relationship satisfaction continues to increase over time after completing treatment (Cloutier et al., 2002; Johnson & Talitman, 1997; Wiebe et al., 2017). Initially, these studies captured these data at one time point 24 and then 36 months after treatment. Recently, a follow up study was conducted assessing the trajectory of relationship satisfaction over time, at 6, 12, 18 and 24-months post-treatment (Wiebe et al., 2017). When comparing pre-therapy to post-therapy scores two years after, this study found a medium effect size of $d = 0.46$. Additionally hierarchical linear modeling found a logarithmic unconditional growth model in which couples' relationship satisfaction increased from pre- to post-therapy scores and then increased at a decelerated rate from post-therapy to two year follow up (Wiebe et al., 2017). Efficacy studies along with assessment of long-term gains provide consistent findings that EFT significantly increases relationship satisfaction and healthy attachment (Clothier et al., 2002; Dandeneau & Johnson, 1994; Denton, Burleson et al., 2000; Goldman & Greenberg, 1992; Halchuk et al., 2010; James, 1991; Johnson & Greenberg, 1985a; Johnson & Greenberg, 1985b; Johnson & Talitman, 1997; Wiebe et al., 2017).

Meta-analytic reviews combine results to provide estimates of general effects of

treatment. EFT has been the focus of two meta-analyses (Johnson, Hunsley, Greenberg, & Schindler, 1999; Lee, Spengler, Wittenborn, & Wiebe, 2019), and three meta-analytic reviews have compared EFT to other approaches (Dunn & Schwebel, 1995; Rathgeber, Burkner, Schiller, & Holling, 2018; Wood, Crane, Schaalje, & Law, 2005). In 1999, Johnson and colleagues published meta-analytic results on four randomized controlled trials of EFT that included a no-treatment comparison group and that were judged to be of high quality, for an estimated mean effect size of $d = 1.31$ (Johnson et al., 1999). These findings are large in comparison to the average effect size for psychotherapy of $d = 0.75$ to 0.85 (Wampold & Imel, 2015) and overall meta-analytic findings for couple therapy that range from $d = 0.53$ (Shadish & Baldwin, 2005) to $d = 0.84$ (Shadish & Baldwin, 2003). A current and more comprehensive analysis of extant EFT outcome research estimates an effect size of $d = 0.98$ (Lee et al., 2019). In a meta-analysis that included EFT as one of two Insight Oriented Marital Therapies (IOMT), post-treatment relationship scores for the experimental and control groups found a Glass' effect size of $\Delta = 1.37$, compared to 0.78 (Behavioral Marital Therapy) and 0.71 (Cognitive-Behavioral Marital Therapy) (Dunn & Schwebel, 1995). Notably this study used Glass's effect size, which divides mean differences by the standard deviation of only the control group, in contrast to the pooled standard deviation used in a Cohen's *d* estimation. Thus it provides a more conservative estimate of effects (Dunn & Schwebel, 1995). A more recent meta-analysis comparing Behavioral Couple Therapy (BCT) and EFT, reported an effect size of Hedge's $g = 0.60$ for all studies combined, and an effect size of $g = 0.73$ for EFT specifically (Rathgeber et al., 2018). Notably this study used Hedges' *g,* an effect size estimate comparable to Cohen's *d* that accounts for positive bias within small samples (Rathgeber et al., 2018). Across efficacy outcome research and meta-analytic syntheses of these studies EFT demonstrates large effect sizes. All of these studies

evaluate the strength of evidence for the impact of EFT in well-controlled settings, in which there are high levels of clinical training, supervision, and insurance of treatment fidelity, and there are strict exclusion and inclusion criteria for selection of couples. However, generalizability of these RCT effects to daily practice, where treatment conditions are less controlled, requires further consideration.

Models for mechanisms of change. Investigation into hypothesized active ingredients in therapy models is conducted through process research, such as process-to-outcome, task-analyses and in-session outcome studies (Sexton et al., 2011). An early study exploring process to outcome highlighted "best sessions" of successful EFT treatments, to assess the blamer-softening change event as a necessary active ingredient of the model (Johnson & Greenberg, 1988). Softening of a blaming-pursuing partner was found to be an essential element of successful EFT treatment (Bradley & Furrow, 2007), and has been task-analyzed to map the necessary mini-steps within this change event (Bradley & Furrow, 2004; Bradley & Johnson, 2005). Task analysis of successful resolution of attachment injures resulted in the attachment injury resolution model (AIRM), and successful engagement in the AIRM is linked to better post-treatment outcomes (Makinen & Johnson, 2006). Similarly, two studies have task analyzed the essential steps within the withdrawer reengagement change event (Lee, Spengler, Mitchell, Spengler, & Spiker, 2017; Rheem, 2011). Making inroads into consideration of neuropsychological evidence that EFT is changing patients as hypothesized, pre-therapy and post-therapy fMRI scans collected information on female partners' fear responses when the threat of electric shock was present across three conditions: when they were alone, when they were holding a stranger's hand, and when they were holding their partner's hand (Johnson et al., 2013). The amygdala or "fear center" was less activated in the condition of holding the partner's

hand in the post-therapy fMRI scans, supporting the theoretical prediction that secure attachment bonds increase resilience to stress (Johnson et al., 2013). These studies are important for providing therapists with mini-models of essential change events encapsulated in the larger model, and for empirically validating the hypothesized mechanisms of change.

Various therapist effects, including therapists' abilities to focus, engage, heighten in-session emotional experiencing, and facilitate powerful attachment-focused enactments have been tested for their impact on EFT treatment outcomes (Bradley & Furrow, 2007). There is emerging research for measuring fidelity to the model (Denton, Johnson, & Burleson, 2009), tracking therapist presence in EFT change events (Furrow, Edwards, Choi, & Bradley, 2012), understanding the experience and impact of EFT training (Montagno, Svatovic, & Levenson, 2011; Sandberg & Knestel, 2011), and analyzing the influence of therapist attachment style on treatment outcomes (Wittenborn, 2012). These studies are representative of emerging research on therapist variables impacting treatment outcomes, and limited conclusions can be drawn at this time, without replication and additional evidence.

Contextual efficacy. Contextual efficacy studies demonstrate outcomes for specific client populations, specific clinical problems, and specific service delivery systems (Sexton et al., 2011). Several studies have examined the generalizability of EFT for certain diagnoses and comorbid conditions. These studies of specific conditions have considered EFT outcomes when one or both of the members are childhood sexual abuse survivors (Dalton, Greenman, Classen, & Johnson, 2013; MacIntosh & Johnson, 2008), when the female partner within a heterosexual relationship has clinical depression (Denton, Wittenborn, & Golden, 2012; Dessaulles, Johnson, & Denton, 2003), when one partner regardless of gender has clinical depression (Wittenborn et al., 2018), when the couple has a child with chronic illness (Clothier et al., 2002; Gordon-

Walker, Johnson, Manion, & Clothier, 1996), when the female partner within in a heterosexual relationship is diagnosed with breast cancer (Couture-Lalande, Greenman, Naaman, & Johnson, 2007; McLean, Walton, Rodin, Esplen, & Jones, 2013), when couples present with sexual dissatisfaction (Honarparvaran, Tabrizy, & Navabinejad, 2010) or low sexual desire (McPhee, Johnson, & van der Veer, 1995), when the couple is experiencing infertility (Soltani, Shairi, Roshan, & Rahimi, 2014), and when the couple is raising a child with an Autism Spectrum Disorder (Lee, Furrow, & Bradley, 2017). These studies provide evidence that EFT is efficacious for certain presenting problems through highly controlled studies that are focused on specific client criteria. Recently, a limited number of studies have been conducted with intent to measure EFT under conditions more representative of natural conditions (Kennedy et al., 2017; Weissman et al., 2017; Wittenborn et al., 2018).

Two pilot studies exploring the impact of EFT for specific presenting diagnoses used outpatient settings, but also implemented treatment fidelity checks, making these studies hybrids of efficacy and effectiveness research (Weissman et al., 2017; Wittenborn et al., 2018). The two studies were targeted to address the specific diagnoses of PTSD (Weissman et al., 2017) and depression (Wittenborn et al., 2018). Weissman et al. (2017) compared pre and post-test measures for seven couples in which one member was a veteran with PTSD. The study represents an important attempt to increase the external validity of outcome evidence by observing the impacts of EFT under natural conditions in a VA setting, but is limited in that it measures the treatment outcomes of only one therapist, who was specially supervised for fidelity (Weissman et al., 2017). Wittenborn and colleagues (2018) compared the effects of EFT to couple therapy treatment as usual (TAU) for depression diagnoses. Relationship satisfaction and depression symptoms were assessed through repeated measures collected at each session to allow

modeling of the trajectory of change and to assess the directional nature of changes in relationship satisfaction and individual improvements in mood (Wittenborn et al., 2018). Ten couples in the EFT condition and six in the treatment as usual (TAU) condition were assessed in community practice settings to enhance the external validity of findings, however, efficacy study conditions such as fidelity checks and special supervision for EFT therapists were implemented.

The only prior EFT study to assess treatment as usual without any special controls, diagnostic requirements, or adherence to treatment fidelity was an effectiveness study of a psycho-educational group format of EFT (Kennedy et al., 2017). This study provides evidence for the effect of EFT concepts provided in a psycho-educational setting to non-distressed couples in natural conditions, but does not address the effectiveness of the EFT model in general therapy settings in clinical conditions. With the exception of this group study, no prior effectiveness research has explored treatment outcomes under naturalistic conditions for all presenting problems and without special supervision. To address this issue, the present study compared the effects of EFT as naturally conducted by practitioners in their typical settings, without any additional controls, to efficacy benchmarks.

Effectiveness Research Methodology

Effectiveness research methods have unique goals that differ methodologically from efficacy studies that are characterized by random assignment of participants to experimental groups and experimental rigor emphasizing internal validity (Heppner, Wampold, & Kivlighan, 2008; Nathan, Stuart, & Dolan, 2000; Sexton et al., 2011). Seligman (1995) outlines five characteristics of psychotherapy as it occurs in field practice that are routinely not represented in efficacy studies: a) rather than being of fixed duration, treatment occurs until the client is improved or stops attending, b) treatment is self-correcting and adaptations are made when a

technique is perceived to be not working, c) clients enter treatment because they are actively help-seeking, unlike RCT participants who respond to invitations for treatment, d) clients typically have multiple problems, not one clearly defined problem, and e) outcomes are focused on improvements in both general functioning and relief from specific presenting problems. Critique of how efficacy studies are conducted provides clarity for why effectiveness research methodology is important to the empirical evidence for psychotherapy models. In the following paragraphs past research methodology is reviewed to provide context for methodological decisions for the present effectiveness study.

EFT studies have used a combination of recruitment methods, using samples gathered from public advertisements (e.g., Johnson & Greenberg, 1985a; Denton, Burleson et al., 2000), as well as participants already seeking treatment (e.g., Dalton et al., 2013). Dandeneau and Johnson (1994) recruited "basically happy couples wishing to enhance their relationship" (p. 20). By contrast, Mclean et al., (2013) identified a sample of cancer patients whose marital distress scores were at an intermediate to moderate level, but ruled out couples that were already seeking couple therapy. A sample of female partners with comorbid depression and relationship distress was obtained via public announcements (Denton, Wittenborn et al., 2012), rather than seeking participants who were already being treated for depression.

Once couples are initially recruited, they are screened based on strict inclusion criteria, which often results in a significant narrowing of the sample (Leichsenring, 2004). Consider the criteria for the initial RCT for EFT, “To enter the study, couples had to have been cohabitating for a minimum of one year, to have no immediate plans for divorce, to have received no psychiatric treatment within the last two years, to be free of alcohol or drug problems and primary sexual dysfunction, and not to be presently involved in other psychologically oriented

treatment" (Johnson & Greenberg, 1985a, p. 314). Even in a study that sought to be clinically representative, of 69 assessed participants, 37 did not meet inclusion criteria (e.g., Wittenborn et al., 2018). These and other criteria characterize all of the efficacy outcome studies reviewed thus far. After taking only those participants who meet the criteria for inclusion, EFT studies often routinely screen for levels of distress, keeping only participants with clinically distressed marital adjustment scores (e.g., Dandeneau & Johnson, 1994; Dessaulles et al., 2003). This creates conditions in which regression to the mean is more likely, because high distress scores are expected to trend back toward average.

Other exclusion criterion screens out comorbidity that is typically present in clinical cases. For example, the following exclusion criteria for Wiebe and colleagues (2017) included restrictions such as participants scoring as insecurely attached, not having a history of a psychotic disorder diagnosis, and not having a history of physical or sexual abuse. Thus, through only accepting those participants who meet the criteria for inclusion and exclusion, controlled trials are not representative of the characteristics of outpatient couple referrals. In the present study, couples were naturally help-seeking and were not screened by any inclusion or exclusion criteria other than clinical decision-making by treating EFT therapists regarding couple appropriateness for EFT.

RCT studies typically have a pre-determined number of sessions, often 8 to 12 weeks, to standardize treatment dosage in controlled trials (e.g., Denton, Burleson et al., 2000; Johnson & Greenberg, 1985a). An average treatment in a clinical setting is estimated to be 15-20 sessions, with cases where trauma is present likely requiring up to 35 sessions (MacIntosh & Johnson, 2008). In a study where treatment completion was prioritized over equivalent dosage of treatment, the mean number of sessions was 22.9, with a range of 13-35 sessions (Johnson et al.,

2013). This suggests that number of sessions needed may vary. In the present study, treatment duration was guided by therapist decision-making and naturally occurring client attendance.

In controlled trials, treatment fidelity is of importance and therapists are highly trained and supervised (Leichsenring, 2004). While therapists used in EFT outcome studies vary in level of experience from novice (e.g., Denton, Burleson et al., 2000) to experts (e.g., Johnson et al., 2013), there is a consistently high level of supervision and control for treatment fidelity. In one study therapists engaged in weekly training over a period of 5 months prior to the beginning of data collection, in addition to receiving weekly supervision during the data collection (Dalton et al., 2013). Weekly supervision is typical of most studies (e.g., Dandeneau & Johnson, 1994; Denton, Wittenborn et al., 2012). Measuring and reinforcing therapists' fidelity to the model is necessary in RCTs for internal validity to establish that equivalent treatment is provided. However, under real world conditions, other than therapists' intentions to provide a particular intervention and their own commitment to treatment fidelity, there is no assessment of treatment adherence. In the present study, therapists' engagement in supervision and their fidelity to the model were not specially controlled or monitored. Therapists were sought out, however, who were trained in EFT and who self-identified as actively using Emotionally Focused Couple Therapy.

Effectiveness research is defined by high clinical representativeness, with treatment-seeking populations, case complexity, and treatment as usual, without special supervision (Heppner et al., 2008; Shadish, Matt, Navarro, & Phillips, 2000). A primary challenge of effectiveness research is defining the conditions of an effectiveness study such that it can be considered a reliable and valid study without laboratory controls. Clarity of information about who participated, who conducted the treatment, cost, and any other significant influences are

important factors that are assessed (Leichsenring, 2004). Multiple measures and modeling change over time offer statistical controls to compensate for lack of manipulation of study elements (Leichsenring, 2004; Shadish et al., 2000). Based on the robust accumulation of EFT research, and the need to compliment extant research with tests of the effectiveness of naturally provided EFT, the current study was conducted to collect naturalistic outcomes of the every day practice of EFT without any imposed controls.

Current Study

Rationale. EFT has empirical support for absolute and relative efficacy (e.g., Dandeneau, & Johnson, 1994; Denton, Burleson et al., 2000; Goldman & Greenberg, 1992; James, 1991), contextual efficacy (e.g., Gordon-Walker et al., 1996; Couture-Lalande et al., 2007), mechanisms of change (e.g., Bradley & Furrow, 2004; Bradley & Furrow, 2007), and some patient and therapist variables (e.g., Furrow et al, 2012; Montagno et al., 2011; Wittenborn, 2012; Wittenborn et al., 2018). Three modified effectiveness studies have been published: one efficacy trial was conducted in a natural setting to increase external validity (Wittenborn et al., 2018), one study assessed a group treatment modification of EFT (Kennedy et al., 2017) and the other assessed the impacts of EFT in a VA setting (Weissman et al., 2017). No prior effectiveness study has attempted to evaluate natural outcomes without special controls, and without targeting specific diagnoses or specific treatment settings. To the impressive body of empirical research for EFT, the present study seeks to add evidence for the naturally delivered effectiveness of EFT in outpatient treatment settings, without specific manipulations, special controls, or strict criteria for participant inclusion or exclusion other than the EFT therapists' natural decision-making. Assessing the effectiveness of EFT as practiced in every day settings offers an additional and key piece of evidence in support of EFT.

Global and specific measures. To capture changes occurring for both the targeted goal of improvement in the couple relationship and information about general improvement, a relationship satisfaction and an individual functioning measure were used. Measures were selected due to their brevity and their frequent use in outcome studies. The Revised Dyadic Adjustment Scale (RDAS) is a common couple therapy outcome measure (Busby, Christensen, Crane & Larson, 1995). Prior EFT studies have included individual measures of functioning (e.g., Weissman et al., 2017), but no EFT studies to date have used the Outcome Questionnaire 30.2 (OQ-30.2). The OQ-30.2 is a shortened version of the original Outcome Questionnaire 45, the first of many OQ assessments used with the OQ-Analyst system used to track outcomes and provide feedback on change trajectories in the areas of subjective discomfort, problems in interpersonal relationships, and problems in social role performance (Lambert, 2015; Wampold & Imel, 2015). Inclusion of an outcome questionnaire measure provided an assessment of global individual functioning and allowed comparison of outcomes to prior studies examining individual functioning outcomes for large sample sizes (Minami, Wampold et al., 2008).

Prior findings indicate the Revised Dyadic Adjustment Scale (RDAS) and the Outcome Questionnaire 45 (OQ 45) measure different constructs (Poll, 2006). Correlation between the RDAS and OQ 45 total scores was $r = 0.43$ for a distressed population and $r = 0.34$ for a non-distressed population, indicating weak to moderate correlations between the total scores for the scales. While this correlation data is not available for the RDAS and OQ-30.2, the OQ-45 and OQ-30.2 function substantially the same (Ellsworth, Lambert, & Johnson, 2006).

Inclusion of an individual functioning measure allowed for exploration of prior findings that EFT improves individual functioning. Because safe attachment within close relationship provides a secure base that facilitates regulation of negative and positive affective states

(Mikulincer & Shaver, 2007), prior EFT studies have explored the impact of secure relationship dynamics on individual outcomes, with demonstrated positive effects for constructs such as depression (Dessaulles et al., 2003) and illness (Couture-Lalande et al, 2007; McLean et al., 2013). However, more recently, Wittenborn et al. (2018) found that the directional nature of improvements in relationship satisfaction and individual recovery was unclear. For some cases relationship satisfaction pre-empted a decrease in depression and for some cases the inverse was true (Wittenborn et al., 2018). Inclusion of both measures provided opportunity to further explore the relationship between individual functioning and relationship satisfaction.

Benchmarking. Benchmarking allows for comparison of findings from efficacy and effectiveness research (Hunsley & Lee, 2007). It is a comparatively new method of bridging research and practice (Minami, Serlin et al., 2008), and consists of establishing standards from aggregated data from representative RCTs or meta-analytic reviews that serve as comparison points for acceptable levels of effectiveness outcomes. In the present study, benchmarking was used to compare the effectiveness of EFT to clinical trial outcomes of EFT studies.

Hypotheses. EFT is a manualized treatment designed to improve relational bonds (Johnson, 2004). Because safe attachment provides a secure base for individual growth (Bowlby, 1988; Mikulincer & Shaver, 2007), EFT is hypothesized to improve individual functioning (e.g., Couture-Lalande et al, 2007; Dessaulles et al., 2003; McLean et al., 2013; Wittenborn et al., 2018). For the present study treatment change trajectories were hypothesized to best fit a three level model in which relationship satisfaction and individual functioning improved over time within individuals and couples.

RCTs of couple therapy typically find large effects, while couple psychotherapy effectiveness outcomes tend have small-to-moderate effects (Halford et al., 2016). When

comparing efficacy outcomes to effectiveness a "good enough" principle of equivalence is employed in which outcomes within $d = 0.2$ are considered equivalent (Minami, Wampold et al., 2008). A natural history benchmark providers an estimate of change occurring over time without intervention. For the present study, for relationship satisfaction outcomes a natural history benchmark of $d = -0.06$ was taken from Baucom, Halweg, and Kuschel (2003) and an efficacy benchmark of $d = 0.98$ was taken from Lee et al. (2019). It was hypothesized that couples would demonstrate statistically and clinically significant improvements in relationship satisfaction from first to last measure with small-to-moderate effect sizes that were better than the natural history benchmark and equivalent to the efficacy benchmark. For individual functioning, Minami, Wampold and colleagues (2008) established benchmarks at $d = 0.15$ and $d = 0.93$, for natural history and efficacy outcomes respectively. It was hypothesized that individuals would demonstrate statistically and clinically significant increases in individual functioning from first to last measure that were better than the natural history benchmark and equivalent to the efficacy benchmark.

Method

Participants

The participants consisted of 11 couples of which 12 individuals self-identified as female and 10 individuals self-identified as male. Of the 20 individuals who chose to respond to the remaining demographic questions 17 self-identified as Caucasian/White, one self-identified as Hispanic, and two self-identified as Multiracial. Seventeen self-identified as heterosexual, two self-identified as lesbian, and one self-identified as bisexual. Seven couples were married, two were engaged, and two were co-habitating. The average relationship length was 13.9 years (SD = 9.9), with a range of 1 to 32 years. Mean age at baseline was 47.5 years (SD =10.64), with a

range of 30 to 68 years. The average number of prior committed relationships was 2.4 (*SD* = 2.95), with a range of 0 to 9 prior relationships. The average household size was 3.1 (*SD* = 1.41), with a range of two to six people. Reporting their highest level of education, three had a high school diploma, one attended technical school, five had undergraduate degrees, six had master's degrees, and five had doctoral degrees. Mean total household annual income was 280,722 US dollars (*SD* = 117,400 dollars), with a range of 125,000 to 450,000 dollars. One couple reported having a child with significant support needs.

Per therapists' report, three participants had notable life-altering medical illnesses (cancer, stroke, and colitis), and 11 participants were given diagnoses from the Diagnostic and statistical manual of mental disorders (DSM-5; American Psychiatric Association, 2013). Diagnoses were present with the following frequencies: anxiety (5), alcohol use disorder (4), depression (2), dysthymia (1), posttraumatic stress disorder (1), and sexual desire disorder (1). Childhood trauma was reported as present in eight of 11 couples with the following frequencies: undisclosed (5), witness to domestic violence (2), childhood sexual abuse (2), childhood physical abuse (1), and parental abandonment (1). Adult trauma was reported as present in five of 11 couples, with the following frequencies: loss of parental rights (1), traumatic death of immediate family member (1), intimate partner violence in a past relationship (2), infidelity in a past relationship (1), and divorce (1). Five couples were reported as having attachment injuries due to affairs, two couples were listed as having attachment injuries due to threats of separation, and one couple was listed as having an attachment injury due to domestic violence within the current relationship.

Power analysis. Multilevel model analyses have limited options for a priori estimation of sample size and statistical power. Sample size for multilevel modeling (MLM) is typically

estimated through simulations (Maas & Hox, 2005). Maas and Hox (2005) suggest a rule of thumb principle that a minimum of 50 participants at the group level to achieve power for analysis. A simulation study for multilevel modeling, using a medium effect size of $d = .30$ (Cohen, 1988) and residual variance of .05, found that 50 participants at the highest level were needed to achieve statistical power of .80 (Maas & Hox, 2005). Initially recruitment for this study was conducted with intent to assess 50 therapists at Level 3 to compare therapist effects and training levels. An *N* of this magnitude was not achieved. As MLM is increasingly employed for small *N* designs, clarity about power for small sample sizes is emerging (Ridenour, Wittenborn, Raiff, Benedict & Kane-Gill, 2016). The most basic test of power for analysis is that convergence occurs and the effects are significant when the model is tested (Hoyle & Gottfredson, 2015). Inference is possible for fixed effects when 30 or more level 1 units are present or when approximately 10 groups are present (Hoyle & Gottfredson, 2015). Furthermore, prior precedent demonstrates growth models fit successfully with samples as small as 17 and 22 couples (Atkins, 2005; Wittenborn et al., 2018). The current sample had sufficient power to achieve significant results in the models run with well beyond 30 units at level 1, and as evidenced by convergence of the model with significant results for variance.

Therapists

Seven EFT trained therapists, consisting of one self-identified male and six self-identified females, participated in the study. All therapists practiced in the United States, with one located in the South, three in the Midwest, and three in the West. Six therapists self-identified as Caucasian/White and one as Other. Mean age of therapists was 51.57 ($SD = 10.14$) years with a range of 36 to 63 years. Three therapists were licensed as psychologists, two as clinical social workers (LCSW), one as a marriage and family therapist (LMFT), and one was dually licensed

as a marriage and family therapist (LMFT) and clinical marriage and family therapist (LCMFT). On average therapists had 21.36 (*SD* = 9.83) years of experience practicing therapy with a range of 9.5 to 36 years. Three therapists completed Core Skills/Advanced Externship training, three are Certified EFT therapists, and one is an EFT Trainer (for definition of training levels, see Appendix B). For experience practicing EFT, therapists had an average of 6.86 years, with a range of 2 to13 years (*SD* = 4.06). On average therapists spent 9.39 hours per week engaged in providing or receiving EFT supervision or consultation, watching their sessions or reviewing EFT materials, with a range of 1.75 to 27 hours (*SD* = 10.04). The average appointment cost was 162 dollars, with a range of 125 to 200 dollars (*SD* = 29.44). All seven therapists were in private practice settings (see Table 1, Appendix C).

Procedures

Therapist recruitment. At the time of recruitment, according to the ICEEFT website (www.iceefft.com) worldwide there were 39 Certified EFT Trainers, 117 Certified Supervisors, 240 Certified Therapists, and 2230 therapists who had completed an externship and/or core skills training, and were members of ICEEFT. Recruitment was done through periodic postings on the ICEEFT listserv and by email and telephone communication to those listed in the ICEEFT directory of EFT therapists (for recruitment letter, see Appendix E). Due to the smaller number of therapists at higher levels and due to their contact with trainees in lower levels, efforts were made to contact all EFT Trainers individually regarding their availability to participate in the study and their willingness to invite others whom were involved in their supervision or training meetings. This included reaching out through personal contacts, email, and follow up telephone contact when telephone information was available. Certified Trainers and Certified Supervisors were sent the recruitment letter through email. Follow up telephone contacts where made when

telephone contact information was available. Seven therapists who facilitated communication for their EFT center issued emails and newsletter announcements regarding the study. When therapists responded with interest in the study, the principle investigator (PI) provided an email to explain the study, provide study materials, and address questions regarding participation, and scheduled a Skype or telephone call to explain information and address questions in detail.

A total of 99 therapists responded to the research invitation (for recruitment flow diagram, see Figure 1, Appendix D). Of those who responded, 48 therapists declined to participate and 31 did not continue after study information was provided. Three therapists agreed to participate, but ended participation when they encountered difficulties with data collection. Ten therapists agreed to participate, but had no clients agree to participate. Seven therapists who agreed to participate had clients who were eligible and agreed to participate. Therapists provided various reasons for declining participation, most frequently citing busyness, particularly with the demands of private practice, as their reason for declining. Other reasons given for not participating included a full caseload with limited availability for new cases; a focus on supervision, training, or writing that decreased their engagement in providing counseling services; a perception that due to integration of other methods their treatment as usual for couples did not constitute EFT practice; concern that inviting couple participation would detract from treatment or couples would find it overwhelming to be recruited when experiencing couple distress; and worry that they did not adequately understand the materials or procedures. The PI provided support for these concerns, and did not pressure therapists in a manner that would constitute coercion to participate in the study. Therapists who did participate indicated reasons for doing so including desire to contribute to research, interest in using research in their practice, familiarity with implementing assessment in their practice, interest in improving their practice of

EFT, and a desire for smoother insurance reimbursement processes as a result of more evidence that EFT works in naturally occurring clinical settings.

Couple recruitment. Therapists were instructed to request participation from the next 5 couples in their practice that were seeking couple therapy and whom the therapist assessed as appropriate for EFT. Johnson's (2004) manual for EFT stipulates that EFT is not appropriate to use in cases of active domestic violence and when substance abuse problems are present. Although this is present as exclusion criteria in the manual, therapists made independent clinical decisions about whether they would provide EFT. The present study relied on the therapists' clinical judgment, and accepted all cases in which therapists indicated they used EFT. There were no limitations on demographic or relationship information placed on couples. Therapists who wished to ask additional couples in order to attempt to have two to five couples in the study were encouraged to do so. Therapists who wished to stop asking new couples after they had asked five were allowed to do so.

Data collection. The seven therapists who had participating clients completed a letter of support allowing research to be conducted at their site, the therapist informed consent form, and therapist demographic form prior to beginning data collection (see Appendices F, G, and H). Participating therapists used a recruitment letter provided by the PI to introduce the study to their couples and were given a flow chart of tasks to facilitate data collection (see Appendices I and J). Therapists were assigned a code for each member of their participating couples, and used this letter-number code on all data sent to the PI. This allowed for collection of de-identified data, compliant with the Health Insurance Portability and Accountability Act guidelines for the Safe Harbor method (HIPAA; U.S. Department of Health & Human Resources, 2012). At the time of agreement to participate couples completed informed consent documents, client demographic

form, and initial research measures (see Appendices K, L, M, N).

Couples were asked to complete two measures at every session throughout their treatment, namely, the Revised Dyadic Adjustment Scale (RDAS; Busby et al., 1995, see Appendix M) and the Outcome Questionnaire 30.2 (OQ-30.2; Lambert, Finch, Okiishi & Burlingame, 2005; see Appendix N). Couples were asked to complete the Couples Therapy Alliance Scale after the third session (CTAS; Pinsof, Zinbarg, & Knobloch-Fedders, 2008; see Appendix O). Participants were able complete all measures online through Qualtrics (Qualtrics, 2015) or a paper-and-pencil version provided in session. Therapists provided the Qualtrics web link or paper-and-pencil versions based on their perception of what would work best in their practice with their client circumstances. Of the 17 couples that initially agreed to participate, ten couples completed online measures and seven completed paper-and-pencil measures. Notably, participants were more likely to complete measures when using paper-and-pencil versions. The six couples not included in final data analysis due to having insufficient data all completed online measures. Therapists who faxed the information typically did so after each session. Thus, the PI received regular installments of data. Therapists who chose to mail back the information did so in batches of several sessions at once. Therapists were reminded to have their couples complete the CTAS (Pinsof et al., 2008) after the third couple session (see Appendix N). Finally, therapists completed a termination form for each couple, to report the average length of sessions and to report medical health, mental health, and relationship history information that they deemed relevant to the course of treatment (see Appendix P). Therapists provided all information in the termination document based on their clinical observations of the cases. Therapists were periodically reminded to ask new couples to participate, and were periodically reminded via their preferred contact method to continue collecting measures to minimize missing data. Data were

collected from December 2016 – July 2018. Data collection closed when it was deemed that sufficient data had been collected for statistical analysis. At the time data collection closed therapists and couples were provided the option to continue collecting data for future analysis. All couples that were still engaged in therapy at the time data collection closed opted to stop completing measures. No monetary or tangible material was provided to therapists or couples for participation. This project was approved by the IRB at Ball State University (see Appendix Q).

Intervention. Therapists indicated they were using EFT treatment as usual with participating couples and, by report, congruent with treatment as described in the EFT manual (Johnson, 2004). Three therapists noted they commonly used modifications in their EFT practice. One therapist reported a high integration of sex therapy principles applied in stage 3 of consolidation, one reported reliance on an understanding of Imago principles (Luquet, 2006), with notable use of these techniques with one couple in one session during Stage 1 of treatment, and two therapists reported using EFT regardless of addiction and substance use concerns, contrary to recommended rule outs (Johnson, 2004). The therapists regularly using EFT for addiction and substance abuse concerns had three couples participating in the study, all of them with significant medical problems, substance use concerns, and a history of long-lasting affairs. These adaptations are what naturalistic studies attempt to capture, as therapists bring their unique constellation of training and clinical judgment to the complexity of their clinical work.

Measures

Demographic questionnaires. Demographic questionnaires were created to assess relevant characteristics of the therapists and couples. Therapist demographic variables included age, gender, race/ethnicity, professional training information, EFT Training Level, years practicing EFT, and estimated time spent in supervision and consultation over the prior month.

Finally, they were asked to report the estimated length of their typical session and the amount in dollars they charge for each session (see Appendix L). Couple demographic variables included age, gender, race/ethnicity, sexual orientation, estimated household annual income, years of education, and occupation. General relationship information was requested including years in current relationship, status of relationship (co-habitating, engaged, married), number and length of prior committed relationships, number of children, and the presence of children with special care needs (see Appendix M).

Revised Dyadic Adjustment Scale (RDAS). The RDAS was created from factor analyses of the Dyadic Adjustment Scale (DAS; Busby et al., 1995; Spanier, 1976). Busby et al., (1995) assessed construct validity and deleted items to achieve acceptable levels of validity for the subscales. These subscales represent three second-order concepts: consensus, satisfaction, and cohesion. Convergent validity for the total scale was tested with the Locke-Wallace Marital Adjustment Test and DAS, with correlations of .67 and .97 respectively (Busby et al., 1995). Furthermore, split-half reliabilities range from .90 to .95 (Busby et al., 1995), with a Cronbach's alpha of .90, and a 14 to 28 day test-retest reliability of .82 (Anderson et al., 2014). The scale has an 81% accuracy rate in distinguishing distressed and non-distressed couples, defined as couples that were either in clinical or non-clinical groups (Busby et al., 1995). Regarding specificity, 86% of those in the nonclinical population were correctly classified as not distressed. Regarding sensitivity, 74% of those in the clinical population were correctly classified as distressed (Busby et al., 1995). Items are rated on a six-point scale from "Always Agree" to "Always disagree". Examples of items include: Agreement on "Religious matters", "Demonstrations of affection", and "Making major decisions." Scores range from 0 to 69. A score of 48 or above on the RDAS is considered in the non-clinical range, with higher scores indicating better adjustment (Anderson

et al., 2014; Crane, Middleton, & Bean, 2000). Anderson and colleagues (2014) used a regression equation with clinical and nonclinical populations to estimate a reliable change index of 12 points. Total scores were used in the present study. The mean score at baseline was 44.36 (*SD* = 6.91) and at termination was 47.77 (*SD* = 6.04) (see Appendix L).

Outcome Questionnaire 30.2 (OQ-30.2). The Outcome Questionnaire 30.2 (OQ-30.2; Lambert et al., 2005) is a brief version of the Outcome Questionnaire 45.2 (Lambert et al., 1996). The brief version is made up of the 30 OQ-45 items most sensitive to change, and was designed to diminish the demands of time when used as a repeated measure. Both measures were designed for use repeatedly across treatment (Ellsworth et al., 2006). This measure is sometimes used under the alternative title Life Status Questionnaire (Lambert et al., 2000). It measures patient progress in the following three dimensions: subjective discomfort, interpersonal relationships, and social role performance. An internal consistency of .93 and test-retest reliability of .84 are reported (Lambert et al., 2000). Concurrent validity for the total score with other similar measures are as follows: Global Severity Index of the Symptom Checklist Revised (*r* = .70), Inventory of Interpersonal Problems (*r* = .62), Social Adjustment Scale (*r* = .59), and Beck Depression Inventory (*r* = .61) (Minami, Wampold et al., 2008). Items are scored on a five-point scale. The range of possible scores is 0 to 120 with higher values indicating higher levels of client distress (Ellsworth et al., 2006). A score of 43 or above is considered to be in the clinical range (Ellsworth et al., 2006). A reliable change index of 10 was estimated for both clinical and nonclinical populations (Minami, Wampold et al., 2008). Total scores were used in the present study. The mean score at baseline was 31.82 (*SD* = 11.10) and at termination was 29.41 (*SD* = 13.79) (see Appendix M).

Couples Therapy Alliance Scale (CTAS). Originally a 28-item Likert-type scale developed by Pinsof and Catherall (1983), the CTAS was factor analyzed and shortened to 12 items measuring the alliance between the Self, the Group, and Other (Pinsof et al., 2008). The restructured form consists of questions addressing "the therapist and me," the "therapist and us," "my partner and the therapist," and "my partner and I." Inter-correlations of the three subscales are .83 (Self-Group/Other), .68 (Self-Group/Within), and .66 (Other/Within). All subscales have alphas of .70 or better (Pinsof et al., 2008). Construct validity was tested by using CTAS scores to predict retention in therapy and change as measured by number of sessions attended and a composite of scales selected from the Martial Satisfaction Inventory Revised, for female patients (Pinsof et al., 2008). The total score was used in the present study. Seven participants did not complete the measure. Among the 15 that did, the mean score was 71.33 (*SD* = 7.88) (see Appendix N).

Research Design

The present study is a quasi-experimental, within-subjects, repeated measures design (Heppner et al., 2008). Therapists were obtained by convenience and were asked to invite their naturally occurring clinical referrals to participate. Thus, couples were also obtained by convenience with no random assignment. The repeated dependent measures assessed the constructs of relationship satisfaction and individual functioning.

Results

To analyze the collected data, first descriptive information about cases was reviewed with cases sorted as improved, recovered, no change or deteriorated, as defined by cut-off scores and reliable change indices. Then, multilevel modeling (MLM) was used to analyze the shape and rate of change for relationship satisfaction and individual functioning. MLM is effective for use

with repeated measures nested data in small samples (Raudenbush & Byrk, 2002; Tasca & Gallop, 2009), and accounts well for nested data, missing data, and variances in number of time points per case (Singer & Willet, 2003). Additionally, paired *t*-tests were then used to examine mean change of treatment on the scale score outcomes. Finally, Cohen's *d* effect sizes calculated for the dependent variables were used for comparison to findings from meta-analyses of prior EFT studies via benchmarking.

Data Completeness/Missing Data

End of therapy data was considered the last time point collected from the client, as is often done in naturalistic settings (Minami, Serlin et al., 2006). The naturalistic nature of the research design must allow for clients to terminate therapy unexpectedly, not reschedule, or decline completing outcome monitoring forms (Hewison, Casey, & Mwamba, 2016). Couples data were analyzed when they provided data for at least four consecutive time points. Two couples were excluded because they did not provide data beyond three initial sessions. Four couples were excluded due to less than four data points provided by one member of the couple even when the other member had provided four or more data points. For the 11 cases that were included, where one member of the couple provided data for a session and the other did not, or where the therapist reported no data collection, some missing data points could be estimated. Of a total of 284 observation points there were 17 missing data points for the RDAS and 17 missing data points for the OQ30.2. These data points were considered missing at random (MAR). Maximum likelihood estimation (MLE) for hierarchical models efficiently uses all of the available time points to estimate the model allowing for unbiased estimation of treatment effects (Raudenbush & Byrk, 2002).

Descriptive Data

At the time data collection closed, of the 11 participating couples, three had completed treatment, with their therapists estimating that they had engaged in the final stage 3 steps of the model. Three couples remained together and were continuing in treatment together. Two of these couples were assessed by their treating therapists as engaged in stage 2 restructuring and repair work and one was considered to be in stage 1. Three couples stopped treatment without completing a full course of treatment. Two of these were assessed as being in stage 2, and one was in stage 1 at the time they stopped attending therapy. One couple was taking a trial separation and continuing in treatment individually and one couple ended treatment with a decision to separate due to an instance of domestic violence. Thus, at the time data collection ended, 73% (n = 9) of the total sample remained together (see Table 2, Appendix C).

Across all 22 participants' relationship satisfaction scores, as measured by the RDAS, 13 pre-test responses were in the clinical range and nine started in the satisfied (non-clinical) range. Seven end scores were in the clinical range and 15 were in the satisfied range. Three relationship satisfaction scores changed to an extent that reliable change was present (Jacobson & Truax, 1991). Where healthy relationship satisfaction scores for both individuals within the couple were present, 63% (n = 7) of couples were not distressed, and thus would be categorized as "improved". Reliable change was present for both individuals in only one couple. Thus, one couple out of 11 couples can be considered "recovered" (Jacobson & Truax, 1991). Across all 22 participants' individual functioning scores, as measured by the OQ 30.2, three baseline scores were in the clinical range and 19 started in the healthy (non-clinical) range. Two ended in the clinical range and 20 ended in the healthy range. Six participants (27%) had improvements and four (18%) had deteriorations that constituted reliable change (see Table 3, Appendix C).

Multilevel Modeling

Repeated measures at the individual level (Level 1) were compared between individuals (Level 2), and individuals were nested within couples (Level 3) using Stata software (StataCorp, 2017). Models were estimated for each dependent variable. As recommended by Singer and Willett (2003), empirical growth plots and ordinary least squares (OLS) plots were examined for individual cases prior to model estimation. Although linear and quadratic equations were present in the OLS plots, a linear equation was a better fit for most cases. Simple models were compared to incrementally more complex models using Akakie's Information Criteria (AIC), Bayesian Information Criteria (BIC), and the $\chi 2$ log likelihood ratio to compare model fit (Raudenbush & Byrk, 2002; Singer & Willett, 2003). AIC and BIC scores were also used to determined which covariance structure among independent, exchangeable, identity, and unstructured was the best fit for the data. An independent covariance structure was found to be the best fit for both models. Intraclass correlation coefficients (ICC) greater than zero demonstrate that similarity between values within groups is present (Singer & Willett, 2003). ICC values ranged between 0.35 and 0.71 indicating that the data was appropriate for multilevel modeling (see Tables 4 and 5, Appendix C).

Relationship satisfaction. For relationship satisfaction the unconditional growth model was a better fit than the unconditional means model, $\chi 2 = 22.68$ ($p < 0.001$), suggesting that inclusion of time better explained the data. The AIC and BIC, as well as the likelihood ratio test, $\chi 2 = 45.31$ ($p < 0.001$), showed the random intercept/slope model was superior. This model found significant results for relationship satisfaction varying over time, across individuals, and within couples, indicating that inclusion of these variables were appropriate for the model. A final model was run testing individual functioning as a time varying predictor of relationship satisfaction, to test an exploratory hypothesis that individual functioning and relationship

satisfaction are both strongly correlated with time across treatment. The improved fit in comparison to the prior model, $\chi 2 = 21.64$ ($p < 0.001$), suggests that consideration of individual functioning scores better explained relationship satisfaction outcomes. In the final unconditional growth model, the linear growth rate for relationship satisfaction is estimated at 0.27 points per session (see Figure 2, Appendix D). A one-unit increase in relationship satisfaction is associated with a 0.15 point improvement in individual functioning across time points. Random factors showed variance within individuals, $\sigma^2 = 11.54\ (1.107)$ and between individuals, $\sigma^2 = 6.71$ (3.90), with small variance related to time, $\sigma^2 = 0.07$ (0.04) and larger variance at the couple level, $\sigma^2 = 19.20$ (10.36) (see Table 4, Appendix C). Examination of differences for gender found that for females, individual functioning scores were more strongly correlated with relationship satisfaction (see Figure 3, Appendix D).

Individual functioning. For individual functioning scores, in the initial unconditional means and unconditional growth models intraclass correlations for couples at level 3 were low (.021 and .032), suggesting that scores within couples were not similar and not appropriate for multilevel modeling. Thus, a 2 level model was tested for repeated measures (level 1) grouped within individuals (level 2). The unconditional means and unconditional growth models were compared to test whether individual functioning scores changed across time. Fit statistics indicated the unconditional growth model better explained the data, $\chi 2 = 8.59$ ($p < 0.01$). The model considering time as both a fixed and random factor had a non-significant parameter estimate for time ($p = 0.26$), and the initial unconditional growth model was retained. As Model D resulted in a significantly better fit to the data compared to the intercept only model, $\chi 2\ (1) = 11.208$, $p < .001$, this model was retained as the best fit. For the final unconditional growth model, the linear growth rate for individual functioning is estimated at 0.22 points per session

(see Figure 4, Appendix D). Variance was present within individuals, σ^2 = 0.327 (.195) and between individuals, σ^2 = 92.461 (30.800), but variance for change across time was not present (see Table 5, Appendix C).

Pre-Posttest Analyses

Paired *t*-tests were used to examine pre–posttest treatment mean change on the scale score outcomes at the individual level. Pre-posttest measures were simply defined as the first and last scores taken from the participant. Cohen's *d* effect sizes were then calculated for each dependent variable, with interpreted effect sizes of 0.2, 0.5, and 0.8 considered small, medium, and large (Cohen, 1988). Cohen's *d* effect size for the present sample was calculated using the formula provided in Minami, Wampold et al. (2008), which accounts for sample size and use of dependent samples. Participants showed significant improvement in relationship satisfaction from first measure (*M* = 44.36, *SD* = 6.91) to last measure (*M* = 47.64, *SD* = 5.99), *t* (21) = 2.566, *p* = .018 with *d* = 0.46 (95% *CI* = -0.14, 1.10) approaching a medium effect. Participants' individual functioning showed statistically non-significant reductions from first measure (*M* = 31.82, *SD* = 11.10) to last measure (*M* = 28.82, *SD* = 14.48), *t* (21) = 1.103, *p* = .282. The effect size of *d* = 0.21 (95% *CI* = -0.40, 0.82) is considered to be small and for the obtained *N* = 22 had statistical power of 0.16. An *N* of 180 would be needed to detect a statistically significant effect (see Table 6, Appendix C).

Benchmarking

Results were analyzed for significance in comparison to previously established benchmarks, to compare naturally occurring clinical practice outcomes to controlled research outcomes (Minami, Wampold et al., 2006). Minami, Serlin, and colleagues, (2008) suggest a "good enough" principle of equivalence to benchmarks when the effect size differences are less

than $d = 0.2$. Another relevant comparison is if an effectiveness effect exceeds natural symptom trajectory, reflected by effect sizes estimates that are 0.2 above the natural history benchmark (Minami, Wampold et al., 2008).

Relationship satisfaction benchmarks. For relationship satisfaction, a natural history benchmark was taken from Baucom et al., (2003) where a meta-analysis of mean effect sizes for waitlist control groups in couples therapy found an effect of $d = -0.06$. Efficacy benchmarks were used from Lee et al.'s (2019) comprehensive meta-analysis, with a reported $d = 0.98$. The relationship satisfaction effect size $d = 0.46$ is significantly larger than the natural history benchmark, but does not meet the range needed for equivalence with the efficacy benchmark. This suggests change in the clinical setting has a meaningful effect compared to no therapy, but clinical effectiveness for the present sample was not equal to outcomes of prior clinical trials from efficacy studies.

Individual functioning benchmarks. For individual functioning, benchmarks were taken from Minami, Wampold and colleagues (2008) estimates of treatment outcomes for the Outcome Questionnaire 30.2 in a sample from a large behavioral health system. Minami, Wampold et al. (2008), leading researchers in the area of benchmarking, constructed an efficacy effect size from a subset of the data collected from 99,004 adult patients that "approximated those who completed treatments in clinical trials" (p. 119), based on length of treatment and number of treatment sessions. This study establishing efficacy benchmarks for the Outcome Questionnaire has set the standard for benchmarking (Minami, Wampold et al., 2008), and was deemed to have established an appropriate comparison point for individual functioning for the present study. Notably, this benchmark is derived from change occurring in individual treatment and provides a stringent comparison point for the impacts of couple therapy on individual

change. Natural history and efficacy benchmarks for individual functioning were $d = 0.15$ and $d = 0.93$ respectively. The individual functioning effect size $d = 0.21$ did not exceed the minimum expectation of 0.2 above the natural history benchmark of $d = 0.15$. For the current sample, EFT treatment did not impact individual functioning beyond change expected without treatment (i.e. natural history).

Discussion

This study sought to address an important missing component in an otherwise comprehensive body of research that has established EFT as an evidence-based couple therapy. EFT has substantial research evidence in all three categories of Sexton and colleagues' (2011) framework for categories of evidence, but the first category, *Absolute efficacy/effectiveness and Relative efficacy/effectiveness,* contains many efficacy studies and no effectiveness studies. The two prior studies approximating effectiveness methodology with couples in every day practice were targeted towards specific diagnoses and used special fidelity checks, and are thus categorized as evidence for contextual efficacy (e.g., Weissman et al., 2017; Wittenborn et al., 2018). This study stands alone as the first absolute effectiveness study of EFT and provides important information about the effectiveness of EFT in daily practice.

Adhering to naturalistic research methods, this study made significant attempts to be minimally intrusive and to represent the true experience of EFT therapists and couples in clinical practice. EFT therapists across various geographical locations provided repeated measures outcomes from their naturally occurring clinical practice. Across 11 couples, 284 time points of data allowed for multilevel modeling analysis of the trajectory of change in treatment within individuals and couples. Cohen's *d* effects allowed for comparison to natural history and efficacy benchmarks. Despite mixed relationship outcomes and the complexity of cases in natural

settings, on average, relationship satisfaction scores improving at a rate of 0.27 points per session and a near medium effect size pre to post measurement of $d = 0.46$ indicates that couples seeking relationship help from an EFT therapist can reasonably expect their relationship to improve.

While modest compared to past RCT findings, these small to medium effects are consistent with other couple therapy effectiveness outcomes (Halford et al., 2016). A commonly cited finding for EFT outcome studies is that following EFT intervention 86 to 90% of couples show significant improvement in relationship satisfaction and 70 to 73% of couples demonstrate reliable recovery (Johnson et al., 1999; Wiebe & Johnson, 2016). In the current sample, 63% of relationship satisfaction scores ended in the healthy range. However, it also must be noted that 41% started in the healthy range. In this relatively non-distressed sample, treatment effects produced a net gain of 16%. Fourteen percent of the sample demonstrated reliable recovery, having started in the distressed range and achieving a 12-point improvement in relationship satisfaction scores. Improvement of relationship satisfaction at 0.27 points per session is congruent with findings of relationship satisfaction score improvement of 0.30 points (for males) found by Wittenborn and colleagues (2018). The current results provide emerging evidence that EFT is effective in natural conditions.

Notably, overall the current sample did not present as significantly distressed on the relationship satisfaction measure or the individual functioning measure. Despite these relatively healthy scores, therapists' reports indicated the majority of cases contained elements that would typically lengthen or complicate treatment (Halchuk et al., 2010; MacIntosh & Johnson, 2008). Childhood trauma was reported to be present in 73% of couples and traumatic experiences occurring in adulthood were estimated for 45% of the sample. However, some traumatic events listed included infidelity and divorce, life events that, while difficult, are not listed in the DSM-5

as posttraumatic stress inducing incidents (American Psychiatric Association, 2013). Attachment injuries are also identified as a complication to the typical trajectory of EFT (Halchuk et al., 2010). These were present in 73% of the current sample. Based on these findings, the sample would appear to be considerably distressed and to present significant challenges to a typical EFT treatment package. Despite the couples reporting significant relationship strengths as reflected by self-report on the relationship satisfaction measure, therapists' evaluations of the presenting concerns indicated significant barriers to success, and medium effect sizes indicate significant success in improving relationship satisfaction.

Number of sessions for successful completion of treatment varied, with one completed treatment occurring in as low as five sessions and one ongoing treatment of 30 sessions considered to be in Stage 2 of the treatment process. Interestingly, both cases with reliable change in relationship satisfaction had completed a total of 22 sessions at the time data collection stopped. However, no clear findings about the length of treatment needed for successful outcome were present.

Furthermore, an important distinction in couple therapy treatment is whether the goal is to clarify commitment to the relationship or to improve the relationship (Halford et al., 2016). Halford et al., (2016) suggest that individual adjustment can be a meaningful outcome of couple therapy and effectiveness research is an opportunity to gain more information about the impacts of treatment for couples who are clarifying their relationship, rather than overtly seeking improvements in relationship satisfaction. For example, within one couple who were taking a trial separation at the time data collection ended, one individual demonstrated reliable improvement in individual functioning and the other demonstrated reliable deterioration. Consideration of only the relationship outcome for this couple might obscure other benefits

obtained in the couple therapy treatment process. Future effectiveness research might explore the individual and couple outcomes for clarification of relationship commitment versus relationship improvement goals.

The relation between individual functioning and relationship satisfaction is a complex problem, as the directional nature is unclear (Wittenborn et al., 2018). Three other instances of individual deterioration were present in cases that otherwise represented typically expected relationship satisfaction improvements. Relationships in which one partner showed individual deterioration despite improvements in relationship satisfaction might be indicative of individual concerns not related to the couple. However, because EFT treatment facilitates bonding through accessing and clearly sharing primary emotions and attachment needs, it is reasonable to expect greater attention to and disclosure of individual vulnerabilities, particularly for the previously withdrawn partner (Lee et al., 2017). In that case, relationship satisfaction might improve even while individual functioning appeared to deteriorate. Further inquiry into individual and couple factors is needed to more fully explore these findings.

Because improvements in relationship bonds are expected to improve individual functioning (Mikulincer & Shaver, 2012), the relationship between individual functioning and relationship satisfaction has been a source of interest for past studies exploring individual problems, such as depression (Wittenborn et al., 2018) and PTSD (Weissman et al., 2017). Previously, Wittenborn and colleagues (2018) found an unclear relationship between changes in depression and changes in relationship satisfaction, finding in some cases that improvements in depression preceded the relationship change and for other cases, the reverse was true. In the present sample, individual functioning scores improved the model for relationship satisfaction, suggesting that increases in individual functioning were related to improvement in relationship

satisfaction over time. However, individual functioning outcomes were better explained by a model that treated them as individual rather than couple level data and that did not include relationship satisfaction as a predictive factor. This suggests that for the present sample, individual functioning improvements enhanced relationship satisfaction outcomes, but relationship satisfaction did not necessarily improve individual functioning. However, overall, changes in individual functioning were likely limited due to initial scores predominantly falling in a non-clinical range.

The relation between individual functioning and relationship satisfaction varied across gender. Similar to findings that females' trust in their partner is predictive of outcome (Johnson & Talitman, 1997), changes in individual functioning for females were associated with more pronounced changes in relationship satisfaction, while men's individual functioning scores had less impact on their relationship satisfaction scores. These findings continue to support the importance of considering gender when exploring the relationship between individual functioning and relationship satisfaction (Denton et al., 2009; Wittenborn et al., 2018).

Finally, while demographic considerations were not presently included in statistical analysis, consideration for demographic variables is important to the discussion of treatment impacts for the present population. The current sample varied in some respects, with 14% of the sample indicating racial minority status and 14% indicating sexual minority status. This sample was somewhat less racially diverse than other studies, but somewhat more inclusive of sexual minority status, as the majority of couple therapy outcome studies have been conducted with individuals in heterosexual relationships (Spengler, Devore, Spengler & Lee, in press). Relationship status varied widely, with years together ranging from one to 32 years. Household size was small and incomes where relatively high. While educational status varied, the lower

range of income for the present sample, $125,000, is double the reported median household income, $61,372, in the United States (www.census.gov, 2018). Thus the current sample was representative of couples with relatively higher socioeconomic status compared to the average US income. Finally, it should be noted that all participating therapists were in private practice, which may have limited the sample to those individuals who could afford and understood how to access therapy in a private practice setting. When considering the generalizability of these outcome findings, these variables should be considered.

Strengths of the study include obtaining repeated measures data with couples naturally presenting to therapy, a time-intensive research task that has been attempted in EFT studies only one other time (Wittenborn et al., 2018). The repeated measures data obtained allow for early estimates of the rate of change in EFT treatment across time in treatment and provides a foundation for future effectiveness studies. Furthermore, with the exception of the study of EFT psycho-educational groups (Kennedy et al., 2017) no prior studies have attempted to collect data across such geographical distances. Impressively, the current study outcomes provide evidence that EFT is effective beyond natural history, while still accounting for a range of clinical complexity across cases.

While strides were made in implementing effectiveness research methods, some limitations should be noted. The utility of evidence-based treatments is strengthened by evidence that the impacts can be generalized across populations and settings (Sexton et al., 2011). In this study, limitations of generalizability were present, as the current sample was relatively non-distressed and the population was restricted to private practice settings serving mostly Caucasian/white individuals with relatively high incomes. Future research can allow for more comprehensive sampling to represent a diverse population and other practice settings to increase

the generalizability of results to a broader population. Planned comparison for the alliance measure, as a means of controlling for relationship factors impacting therapeutic outcomes (Johnson & Greenberg, 1985a) could not be done due to frequent problems with completion of the alliance scale. The present study did not analyze therapist differences that may contribute to outcomes. Future study with a larger sample size can conduct comparison of different change trajectories and more in-depth consideration of therapist and client variables impacting treatment trajectories.

Implications

The current study offers further evidence for the clinical utility of EFT. EFT is a well-researched, evidence-based model, formulated out of close attention to what worked in real sessions with real clients (Johnson, 2004). Outcomes indicate the EFT model applied under daily practice conditions, across various presenting concerns and without special supervision or fidelity checks, is effective beyond natural history. Indeed, considering findings that couples in wait-list control groups do not typically improve, the small to moderate benefits for individual functioning and relationship satisfaction are a strong indication that EFT therapy is an important public health resource. Future research can build on the current study to further investigate the dissemination, implementation, and sustained adoption of this model in every day practice.

Future research. Effectiveness research methodology addresses important clinical considerations that cannot be addressed in efficacy contexts (Halford et al., 2016). As this well-articulated, theoretically-grounded psychotherapy model is disseminated across the world, therapists have an opportunity to assess its effectiveness with couples in their geographical location, under the unique conditions of their respective work settings, and to provide increased empirical evidence for the transportability of this model. The principal investigator found in

conducting this study that a number of concerns were repeatedly brought up by therapists. Therapists involved in the present study expressed concern for the couples they attempt to help despite issues such as domestic violence and substance use problems. Some therapists noted their caseloads were regularly highly complex, with comorbidity present more often than not. Furthermore, therapists in this study expressed concern for the high number of couples who appear to drop out or terminate early from treatment. EFT therapists were invested in how to best provide services, and were aware of barriers, such as time, that caused them to avoid additional time-pressures, such as requesting that their clients complete outcome measures. In fact, the most common reason for declining participation in the present study was limited time. Additionally, conversations around better insurance reimbursement were frequent; therapists noted the difficulty of investing time and attention to clinical work, while being burdened by the significantly time-consuming requirements of obtaining insurance reimbursement within their private practice. Perhaps these time pressures can be alleviated if amassing practice-based data builds evidence for the appropriateness of reimbursement for positive individual, couple and community outcomes as a result of EFT interventions.

Routine collection of practice data allows practitioners to reflect on their practice, to use feedback to make changes, and to identify what practice questions most urgently need research attention. Practice Research Networks (PRNs), such as the Pennsylvania Psychological Association Practice Research Network (PPA-PRN) demonstrate the pooling of practice based data to assess clinical events and outcomes (Castonguay et al., 2010). The Marriage and Family Therapy Practice Research Network (MFT-PRN), a network that can be joined by both clinicians and researchers to allow for collection of practice data, is another example of attempts to obtain naturalistic outcomes through research networks (Johnson, Miller, Bradford, & Anderson, 2017).

These larger systems for collection of data could be emulated within EFT practice and research. Anecdotally it appears many EFT clinicians are regularly assessing couple relationship satisfaction levels at the time of intake. Measuring this across treatment or at termination and intentionally pooling this data would provide rich evidence for the effectiveness of EFT.

EFT has routinely positive impacts for couples, but it remains that approximately 10 to 20% of couples may not be benefitting from treatment (Johnson et al., 1999; Wiebe & Johnson, 2016). As has been demonstrated by the Outcome System for tracking, the more that is known about average treatment trajectories, the more clinicians can identify those cases that are not average, and adjust treatment to prevent early drop out or deterioration (Lambert, 2015). Routine assessment and feedback studies have been conducted infrequently with couple therapy (Anker, Duncan, & Sparks, 2009), but early evidence suggests practice feedback in couple therapy does improve treatment outcomes (Anker et al., 2009).

Routine outcome assessment can prevent early drop out, improve the treatment trajectory, and allow therapists to cull their daily EFT practice for additional information about how to best implement EFT under natural conditions. EFT leads the couple therapy arena in treatment effects, but without clear accountability that it is being applied rigorously and adapted to local circumstances and hard-to-treat couples, its potential is not maximized. Adding an empirical element to supervision and community support, committed therapists can engage in routine tracking and form research networks to pool their practice data and create large effectiveness studies, providing empirical information to maximize EFT therapy outcomes in daily practice.

Social justice implications. The current study represents only private practice settings and high-income clients. Factors such as low-income and minority status can cause disproportionate challenges to relational bonds (Jackson et al., 2015). Future research might

target community mental health settings and other agencies routinely serving low-income populations, to establish better understanding of the applications of EFT for individuals and couples experiencing the additional vulnerabilities that come with living in chronically high-stress, under-resourced conditions. Future studies may consider in what ways low-income populations have access to and benefit from EFT treatments.

Conclusion

This study provides preliminary data suggesting that couples presenting to treatment for EFT intervention can expect to obtain medium range improvements in their relationship satisfaction. While this study is an important step forward in the empirical evidence for the effectiveness of EFT, many aspects of the effects of EFT in daily practice remain to be assessed. To provide further empirical support to this well-researched model, large effectiveness research trials could be conducted through EFT practitioners regularly collecting and pooling practice data. These findings could then be used to improve the every day clinical practice of EFT by tracking the extent to which couples are following an expected pattern of improvement in treatment, identifying those couples that drop out or do not benefit or maintain gains of treatment for further study on how these couples may be better served, decrease the burden of time and effort that therapists must put into obtaining reimbursement for couples treatment by providing practice-based outcomes to increase insurance coverage, and increase the availability of this efficacious and effective treatment for individuals who may currently have diminished access to couples therapy due to limits in financial resources or access to a trained EFT therapist. In the meantime, couples presenting for therapy can expect to benefit from EFT therapy as provided in every day clinical practice by EFT therapists.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association, Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285. doi:10.1037/0003-066X.61.4.271

Anderson, S., Tambling, R., Huff, S., Heafner, J., Johnson, L., & Ketring, S. (2014). The development of a reliable change index and cutoff for the revised dyadic adjustment scale. *Journal of Marital and Family Therapy, 40* (4) 525-534. doi:10.1111/jmft.12095

Anker, M., Duncan, B., & Sparks, J. (2009). Using client feedback to improve couple therapy outcomes: A randomised clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 77,* 693–704. doi:10.1037/a0016062

Atkins, D. (2005). Using multilevel models to analyze couple and family treatment data: Basic and advanced issues. *Journal of Family Psychology, 19*(1), 98-110. doi:10.1037/0893-3200.19.1.98

Baldwin, S., Wampold, B., & Imel, Z. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75,* 842-852. doi:10.1037/0022006X.75.6.842

Barber, J., Crits-Christoph, P., & Luborsky, L. (1996). Effects of therapist adherence and competence on patient outcome in brief dynamic therapy. *Journal of Consulting and Clinical Psychology, 64*(3), 619-22.

Baucom, D., Hahlweg, K., & Kuschel, A. (2003). Are waiting-list control groups needed in future marital therapy outcome research? *Behavior Therapy, 34*(2), 179-188. doi:10.1016/S0005-7894(03)80012-6

Bowlby, J. (1988). *A secure base.* New York: Basic Books.

Bradley, B. (2001). *The process of blamer softening in emotionally focused therapy*. (Unpublished doctoral dissertation). Fuller Theological Seminary, Pasadena, CA.

Bradley, B. & Furrow, J. (2007). Inside blamer softening: Maps and missteps. *Journal of Systemic Therapies, 26,* 25-43. doi:10.1521/jsyt.2007.26.4.25

Bradley, B. & Furrow, J. (2004). Toward a mini-theory of the blamer softening event: Tracking the moment-by-moment process. *Journal of Marital and Family Therapy, 30*(2), 233-246. doi:10.1111/j.1752-0606.2004.tb01236.x

Bradley B., & Johnson, S. (2005). Task analysis of couple and family change events. In P. Piercy (Ed.), *Research Methods in Family Therapy* (pp. 254-271). New York: Guilford Press.

Busby, D., Christensen, C., Crane, D., & Larson, J. (1995). A revision of the dyadic adjustment scale for use with distressed and non-distressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy, 21*(3), 289-308. doi:10.1111/j.1752-0606.1995.tb00163.x

Byrne, M., Carr, A., & Clark, M. (2004). The efficacy of Behavioral Couples Therapy and Emotionally Focused Therapy for couple distress. *Contemporary Family Therapy: An International Journal, 26(4),* 361-387. doi:10.1007/s10591-004-0642-9

Castonguay, L., Boswell, J., Zack, S., Baker, S., Boutselis, M., Chiswick, N.,...Holtforth, M. (2010). Helpful and hindering events in psychotherapy: A practice research network

study. *Psychotherapy Theory, Research, Practice, Training, 47*(3), 327-344. doi:10.1037/a0021164

Christensen, A., Atkins, D., Baucom, B., & Yi, J. (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative couples therapy. *Journal of Clinical and Consulting Psychology, 78*, 225–235. doi:10.1037/a0018132

Clothier, P., Manion, I., Gordon-Walker, J. & Johnson, S. (2002). Emotionally Focused Interventions for couples with chronically ill children: A two-year follow-up. *Journal of Marital and Family Therapy,* 28, 391-399.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Earlbaum Associates.

Couture-Lalande, M., Greenman, P., Naaman, S. & Johnson, S. (2007) Emotionally Focused Therapy for couples with a female partner who suffers from breast cancer: An exploratory study. *Psycho-Oncology, 1*, 257-264.

Crane, D., Middleton, K., & Bean, R. (2000). Establishing criterion scores for the Kansas Marital Satisfaction Scale and the Revised Dyadic Adjustment Scale. *American Journal of Family Therapy, 28*, 53–60. doi:10.1080/019261800261815

Dalton, J., Greenman, P., Classen, C., & Johnson, S. (2013) Nurturing connections in the aftermath of childhood trauma: A randomized controlled trial of Emotionally Focused Couple Therapy (EFT) for female survivors of childhood abuse. *Couple and Family Psychology: Research and Practice, 2*(3) 209-221. doi:10.1037/a0032772

Dandeneau, M. & Johnson, S. (1994). Facilitating intimacy: Interventions and effects. *Journal of Marital and Family Therapy, 20* (1), 17-33. doi:10.1111/j.1752-0606.1994.tb01008.x

Denton, W., Burleson, B., Clark, T., Rodriguez, C., & Hobbs, B. (2000) A randomized trial of Emotionally Focused Therapy for couples in a training clinic. *Journal of Marital and Family Therapy,* 26, pp. 65-78. doi:10.1111/j.1752-0606.2000.tb00277.x

Denton, W., Johnson, S., & Burleson, B. (2009). Emotion Focused Therapy-Therapy Fidelity Scale (EFT-TFS): Conceptual development and content validity. *Journal of Couple & Relationship Therapy, 8*(3), 226-246. doi:10.1080/15332690903048820

Denton, W., Wittenborn, A., & Golden, R. (2012). Augmenting antidepressant medication treatment of depressed women with Emotionally Focused Therapy for couples: A randomized pilot study. *Journal of Marital and Family Therapy, 38* (1), 23-38. doi:10.1111/j.1752-0606.2012.00291.x

Dessaulles, A., (1991). *The treatment of clinical depression in the context of marital distress.* Unpublished doctoral dissertation, University of Ottawa.

Dessaulles, A., Johnson, S., & Denton, W. (2003). Emotion-Focused Therapy for couples in the treatment of depression: A pilot study. *American Journal of Family Therapy, 31*(5), 345-353. doi.org/10.1080/01926180390232266

Doss, B., Simpson Rowe, L., Morrison, K., Libet, J., Birchler, G., Madsen, J., & McQuaid, J. (2012). Couple therapy for military veterans: Overall effectiveness and predictors of response. *Behavior Therapy, 43,* 216–227. doi:10.1016/j.beth.2011.06.006

Duncan, B. (2010). *On becoming a better therapist.* Washington, DC: American Psychological Association.

Dunn, R., & Schwebel, A. (1995). Meta-analytic review of marital therapy outcome research. *Journal of Family Psychology, 9*(1), 58-68. doi.org/10.1037/0893-3200.9.1.58

Duplassie, D., Macknee, C., & Williams, M. (2008). Critical incidents that help and hinder learning Emotionally Focused Therapy for Couples. *Journal of Couple & Relationship Therapy, 7*(1), 1–18. doi:10.1080/15332690802129689

Ellsworth, J., Lambert, M., & Johnson, J. (2006). A comparison of the Outcome Questionnaire-45 and Outcome Questionnaire-30 in classification and prediction of treatment outcome. *Clinical Psychology & Psychotherapy, 13*(6), 380-391. doi:10.1002/cpp.503.

Eysenck, H. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, *16*(5) 319–324. doi:10.1037/h0063633

Faul, F., Erdfelder, E., Lang, A., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175-191.

Friedlander, M., Wildman, J., Heatherington, L., & Skowron, E. (1994). What we do and don't know about the process of family therapy. *Journal of Family Psychology, 8*(4), 390-416.

Furrow, J., & Bradley, B. (2011). Emotionally focused couple therapy: Making the case for effective couple therapy. In J. Furrow, S. Johnson, & B. Bradley, (Eds.) *The Emotionally Focused Casebook* (pp. 3-30). New York: Brunner Routledge.

Furrow, J., Edwards, S., Choi, Y., & Bradley, B. (2012). Therapist presence in emotionally focused couple therapy blamer softening events: Promoting change through emotional experience. *Journal of Marital and Family Therapy, 38*(1), 39-49. doi:10.1111/j.1752-0606.2012.00293.x

Furrow, J., Johnson, S., & Bradley, B. (Eds.) (2011). *The emotionally focused casebook: New directions in treating couples.* New York: Brunner/Routledge.

Gallop, R., & Tasca, G. A. (2009). Multilevel modeling of longitudinal data for psychotherapy researchers: II. The complexities. *Psychotherapy Research: Journal of the Society for Psychotherapy Research, 19*(4–5), 438–452. doi:10.1080/10503300902849475

Goldman, A. & Greenberg, L. (1992) Comparison of integrated systemic and emotionally focused approaches to couples therapy. *Journal of Consulting and Clinical Psychology, 60*(6), 962-969. doi:10.1037/0022-006X.60.6.962

Gordon-Walker, J., Johnson, S., Manion, I., & Cloutier, P. (1996). Emotionally focused marital intervention for couples with chronically ill children. *Journal of Consulting and Clinical Psychology, 64*(5), 1029-1036. doi.org/10.1037/0022-006X.64.5.1029

Greenberg, L. (2008). Emotion and cognition in psychotherapy: The transforming power of affect. *Canadian Psychology, 49*(1), 49-59. doi:10.1037/0708-5591.49.1.49

Greenberg, L. S., Ford, C. L., Alden, L. S., & Johnson, S. M. (1993). In-session change in Emotionally Focused Therapy. *Journal of Consulting and Clinical Psychology, 61*(1), 78-84. doi:10.1037/0022-006X.61.1.78

Greenman, P. & Johnson, S. (2013). Process research on Emotionally Focused Therapy (EFT) for couples: Linking theory to practice. *Family Process, 52*(1), 46-61. doi:10.1111/famp.12015

Greenberg, L., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review. *Journal of Clinical Psychology, 62*, 611-630. doi:10.1002/jclp.20252

Hahlweg, K., & Klann, N. (1997). The effectiveness of marital counselling in Germany: A contribution to health services research. *Journal of Family Psychology, 11,* 410–421. doi:10.1037//0893-3200.11.4.410-421

Halchuk, R., Makinen, J. & Johnson, S. (2010). Resolving attachment injuries in couples using Emotionally Focused Therapy: A three-year follow-up. *Journal of Couple and Relationship Therapy, 9*, 31-47. doi.org/10.1080/15332690903473069

Halford, W., Pepping, C., & Petch, J. (2016). The gap between couple therapy research efficacy and practice effectiveness. *Journal of Marital and Family Therapy, 42*(1), 32-44. doi:10.1111/jmft.12120

Heppner, P. P., Wampold, B. E., & Kivlighan, D. M. (2008). *Research Design in Counseling* (3rd ed.). Belmont, CA: Brooks/Cole.

Hewison, D., Casey, P., & Mwamba, N. (2016). The effectiveness of couple therapy: Clinical outcomes in a naturalistic United Kingdom setting. *Psychotherapy, 53*(4), 377-387. doi:10.1037/pst0000098

Honarparvaran, N., Tabrizy, M., & Navabinejad, S. (2010). The efficacy of Emotionally Focused couple therapy training with regard to reducing sexual dissatisfaction among couples. *European Journal of Scientific Research,* 43(4), 538-545.

Howard, K., Moras, K., Brill, P., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51,* 1059-1064. doi.org/10.1037/0003-066X.51.10.1059

Hoyle, R., & Gottfredson, N. (2015). Sample size considerations in prevention research applications of multilevel modeling and structural equation modeling. *Prevention Science, 16*(7), 987-996. doi:10.1007/s11121-014-0489-8

Hunsley, J. & Lee, C. (2007). Research-informed benchmarks for psychological treatments: Efficacy studies, effectiveness studies, and beyond. *Professional Psychology: Research and Practice, 38*(1), 21-33. doi.org/10.1037/0735-7028.38.1.21

Jacobson, N., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12-9.

Jackson, G., Trail, T., Kennedy, D., Williamson, H., Bradbury, T., & Karney, B. (2016). The salience and severity of relationship problems among low-income couples. *Journal of Family Psychology, 30*(1), 2-11. doi:10.1037/fam0000158

James, P. (1991) Effects of a communication training component added to an Emotionally Focused Couples Therapy. *Journal of Marital & Family Therapy, 11,* 313-317. doi:10.1111/j.1752-0606.1991.tb00894.x

Johnson, L., Miller, R., Bradford, A., & Anderson, S. (2017). The Marriage and Family Therapy Practice Research Network (MFT-PRN): Creating a more perfect union between practice and research. *Journal of Marital & Family Therapy, 43*(4), 561-572. doi: 10.1111/jmft.12238

Johnson, S. (2007). A new era for couple therapy: Theory, research and practice in concert. *Journal of Systemic Therapies, 26*(4)*,* 5-16. doi:10.1521/jsyt.2007.26.4.5

Johnson, S. (2009). Attachment theory and Emotionally Focused Therapy for individuals and couples. In J. H. Obegi & E. Berant (Eds.), *For Attachment Theory and Research in Clinical Work with Adults,* (pp. 410-433). New York: The Guilford Press.

Johnson, S. (2007b). The contribution of Emotionally Focused Couples Therapy. *Special Edition of Journal of Contemporary Psychology: Humanistic Psychology, 37*, 47-52. doi:10.1007/s10879-006-9034-9

Johnson, S. (2004). *The Practice of Emotionally Focused Couple Therapy: Creating Connection.* New York: Routledge.

Johnson, S. (2003). The revolution in couples therapy: A practitioner-scientist perspective. *Journal of Marital and Family Therapy, 29,* 365-385.

Johnson, S. & Greenberg, L. (1985a). Emotionally Focused Couples Therapy: An outcome study. *Journal of Marital & Family Therapy, 11,* 313-317. doi:10.1111/j.1752-0606.1985.tb00624.x

Johnson, S. & Greenberg, L. (1985b). The differential effectiveness of experiential and problem solving interventions in resolving marital conflict. *Journal of Consulting & Clinical Psychology, 53*(2)*,* 175-184. doi:10.1037/0022-006X.53.2.175

Johnson, S. & Greenberg, L. (1988). Relating process to outcome in marital therapy. *Journal of Marital and Family Therapy, 14*(2), 175-183. doi:10.1111/j.1752-0606.1988.tb00733.x

Johnson, S. & Greenman, P. (2013). Commentary: Of course it is all about attachment! *Journal of Marital and Family Therapy, 39*(4). doi:10.1111/jmft.12035

Johnson, S., Hunsley, J., Greenberg, L. & Schindler, D. (1999). Emotionally Focused Couples Therapy: Status and challenges (A meta-analysis). *Journal of Clinical Psychology: Science and Practice, 6,* 67-79. doi:10.1093/clipsy.6.1.67

Johnson, S. & Lebow, J. (2000). The coming of age of couple therapy: A decade review. *Journal of Marital and Family Therapy, 26*(1), 9-24. doi:10.1111/j.1752-0606.2000.tb00273.x

Johnson, S., Makinen, J., & Millikin, J., (2001). Attachment injuries in couple relationships: A new perspective on impasses in couples therapy. *Journal of Marital and Family Therapy, 27*(2)*,* 145-155. doi:10.1111/j.1752-0606.2001.tb01152.x

Johnson, S., Maddeaux, C., & Blouin, J. (1998). Emotionally Focused Family Therapy for bulimia: Changing attachment patterns. *Psychotherapy: Theory, Research & Practice, 35*(2)*,* 238-247. doi:10.1037/h0087728

Johnson, S., Moser, M., Beckes, L., Smith, A., Dalgleish, T., Halchuk, R.,…Coan, J., (2013). Soothing the threatened brain: Leveraging contact comfort with Emotionally Focused Therapy. *PLOS One, 8*(11). doi:10.1371/journal.pone.0079314

Johnson, S. & Talitman, E. (1997). Predictors of success in Emotionally Focused Marital Therapy. *Journal of Marital and Family Therapy, 23*(2), 135-152. doi:10.1111/j.1752-0606.1997.tb00239.x

Johnson, S., & Zuccarini, D. (2010). Integrating sex and attachment in Emotionally Focused Couple Therapy. *Journal of Marital and Family Therapy, 36*(4)*,* 431-445. doi: 10.1111/j.1752-0606.2009.00155.x.

Kazdin, A. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist, 63*(3)*,* 146-159. doi:10.1037/0003-066X.63.3.146

Kennedy, N., Johnson, S., Wiebe, S., & Tasca, G. (2017). *Conversations for Connection: An outcome assessment of the Hold Me Tight relationship education program for couples* (Unpublished doctoral dissertation). University of Ottawa, Ottawa, Canada.

Kim, D., Wampold, B., & Bolt, D. (2006). Therapist effects in psychotherapy: A random effects modeling of the NIMH TDCRP data. *Psychotherapy Research, 16*(2)*,* 161–172. doi:10.1080/10503300500264911

Klann, N., Hahlweg, K., Baucom, D. H., & Kroeger, C. (2011). The effectiveness of couple therapy in Germany: A replication study. *Journal of Marital and Family Therapy, 37*, 200–208. doi:10.1111/j.1752-0606.2009.00164.x

Lambert, M. (2015). Progress feedback and the OQ system: The past and the future. *Psychotherapy, 52*(4), 381-390. doi:10.1037/pst0000027

Lambert, M., Bergin, A., & Garfield, S. (2004). Introduction and historical overview. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5th ed.) (pp. 3-15). New York: Wiley.

Lambert, M., Finch, A., Okiishi, J., & Burlingame, G. (2005). *Administration and scoring manual for the OQ-30.2: Adult outcome questionnaire for screening individuals and population monitoring.* Salt Lake City, UT: OQ Measures LLC.

Lambert, M., Hansen. N., Umpress, V., Lunnen, K., Okiishi, J., Burlingame, G.,...Reisinger, C. (1996). *Administration and scoring manual for the Outcome Questionnaire (OQ 45.2).* Wilmington, DL: American Professional Credentialing Services.

Lambert, M., Hatfield, D., Vermeersch, D., Burlingame, G. Reisinger, C., & Brown, J. (2000). *Administration and scoring manual for the Life Status Questionnaire.* New Jersey: American Professional Credentialing Services.

Lambert, M., & Ogles, B. (2004). The effectiveness and efficacy of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5th ed.) (pp. 3-15). New York: Wiley.

Lebow, J. (2018). Effectiveness research in couple and family therapy. *Family Process, 57*(2), 271-274. doi10.1111/famp.12367

Lebow, J., Chambers, A., Christensen, A., & Johnson, S. (2012). Research on the treatment of couple distress. *Journal of Marital and Family Therapy, 38*(1)*,* 145-168. doi:10.1111/j.1752-0606.2011.00249.x

Lee, N., Furrow, J., & Bradley, B. (2017). Emotionally Focused Couple Therapy for parents raising a child with an Autism Spectrum Disorder: A pilot study.” *Journal of Marital and Family Therapy, 43*(4), 662-673. doi:10.1111/jmft.12225

Lee, N., Spengler, P., Mitchell, A., Spengler, E., & Spiker, D. (2017). Facilitating withdrawer re-engagement in emotionally focused couple therapy: A modified task analysis. *Couple and Family Psychology: Research and Practice, 6*(3), 205-225. doi:10.1037/cfp0000084

Lee, N., Spengler, P., Wittenborn, A., & Wiebe, S. (2019). *A meta-analysis of Emotionally Focused Couple Therapy*. Unpublished data.

Leichsenring, F. (2004). Randomized controlled versus naturalistic studies: A new research agenda. *Bulletin of the Menninger Clinic, 68*(2)*,* 137-151. doi:10.1521/bumc.68.2.137.35952

Lundblad, A., & Hansson, K. (2006). Couples therapy: Effectiveness of treatment and long-term follow-up. *Journal of Family Therapy, 28*(2), 136–152. doi:10.1111/j.1467-6427.2006.00343.x.

Luquet, W. (2006). *Short-term couples therapy: The imago model in action.* New York: Routledge.

Maas, C. & Hox, J. (2005). Sufficient sample sizes for multilevel modeling. *Methodology: European Journal of Research Methods for the Behavioral and Social Sciences, 1*(3), 86-92. doi:10.1027/1614-2241.1.3.86

MacIntosh, H., & Johnson, S. (2008). Emotionally Focused Therapy for couples and childhood sexual abuse survivors. *Journal of Marital and Family Therapy, 34*(3)*,* 298-315. doi:10.1111/j.1752-0606.2008.00074.x

Makinen, J., & Johnson, S. (2006). Resolving attachment injuries in couples using Emotionally Focused Therapy: Steps toward forgiveness and reconciliation. *Journal of Consulting and Clinical Psychology, 74*(6), 1055-1064. doi:10.1037/0022-006X.74.6.1055

McHugh, R., & Barlow, D. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist, 65*(2), 73–84. doi:10.1037/a0018121

McLean, L., Walton, T., Rodin, G., Esplen, M., & Jones, J. (2013). A couple-based intervention for parents and caregivers facing end-stage cancer: Outcomes of a randomized controlled trial. *Psycho-Oncology, 22*(1). doi:10.1002/pon.2046

McPhee, D., Johnson, S., & van der Veer, M. (1995) Low sexual desire in women: The effects of marital therapy. *Journal of Sex and Marital Therapy, 21*(3), 159-182. doi:10.1080/00926239508404396

Messer, S., & Wampold, B. (2002). Let's face facts: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice, 9,* 21-25. doi:10.1093/clipsy.9.1.21

Mikulincer, M., & Shaver, P. (2012). Adult attachment orientations and relationship processes. *Journal of Family Therapy and Review, 4,* 259-274. doi:10.1111/j.1756-2589.2012.00142.x

Mikulincer, M., & Shaver, P. (2007). *Attachment in adulthood: Structure, dynamics, and change.* New York: Guilford Press.

Minami, T., Serlin, R., Wampold, B., Kircher, J. & Brown, G. (2008). Using clinical trials to benchmark effects produced in clinical practice. *Quality and Quantity, 42*(4)*,* 513-525. doi:10.1007/s11135-006-9057-z

Minami, T., Wampold, B., Serlin, R., Hamilton, E. & Brown, G. (2008). Benchmarking the effectiveness of psychotherapy treatment for adult depression in a managed care

environment: A preliminary study. *Journal of Consulting and Clinical Psychology, 76*(1), 116-124. doi:10.1037/0022-006X.76.1.116

Montagno, M., Svatovic, M., & Levenson, H. (2011). Short-term and long-term effects of training in emotionally focused couple therapy: Professional and personal aspects. *Journal of Marital and Family Therapy, 37*(4), 380–392. doi:10.1111/j.1752-0606.2011.00250.x

Naaman, S., Radwan, K., & Johnson, S., (2009). Coping with early breast cancer: Couple adjustment processes and couple-based intervention. *Psychiatry: Biological and Interpersonal Processes, 72*(4), 321-345. doi:10.1521/psyc.2009.72.4.321

Nathan, E., Stuart, S., & Dolan, S. (2000). Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? *Psychological Bulletin, 126*(6), 964-981. doi:10.0137//0033-2909.j26.6.964

Norcross, J., & Lambert, M. (2011). Evidenced-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidenced-based responsiveness* (2nd ed.) (pp. 3-24). NY: Oxford University Press.

Ollendick, T. (2014). Advances toward evidence-based practice: Where to from here? *Behavior Therapy*, *45*(1), 51–55. doi:10.1016/j.beth.2013.08.004.

Orlinsky, D., Ronnestad, M., & Willutski, U. (2004). Fifty years of process-outcome psychotherapy research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5th ed.). (pp.307-390). New York: Wiley.

Palmer-Olsen, L. (2007). A phenomenological exploration of the EFT therapist's experience of EFT supervision and training. Unpublished doctoral dissertation, California School of Professional Psychology Alliant International University.

Palmer-Olsen, L., Gold, L., & Woolley, S., (2011). Supervising Emotionally Focused therapists: A systematic research-based model. *Journal of Marital and Family Therapy, 37,* 411-426. doi:10.1111/j.1752-0606.2011.00253.x

Paul, G. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting Psychology, 31*(2)*,* 109-118.

Pinsof, W., & Catherall, D. (1986). The integrative psychotherapy alliance: Family, couple and individual therapy scales. *Journal of Marital and Family Therapy, 12*(2), 137-151. doi: 10.1111/j.1752-0606.1986.tb01631.x

Pinsof, W., Zinbarg, R., & Knobloch-Fedders, L. (2008). Factorial and construct validity of the revised short form integrative psychotherapy alliance scales for family, couple, and individual therapy. *Family Process, 47*(3), 281-301. doi:10.1111/j.1545-5300.2008.00254.x

Poll, A., (2006). *The relationship between the Outcome Questionnaire and the Revised Dyadic Adjustment Scale in marital assessment.* All Graduate Theses and Dissertations. 2656. https://digitalcommons.usu.edu/etd/2656

Qualtrics, Provo, UT (2015). Qualtrics [computer software]. Retrieved from http://www.qualtrics.com.

Rathgeber, M., Burkner, P., Schiller, E., & Holling, H. (2018). The efficacy of Emotionally Focused Couples Therapy and Behavioral Couples Therapy: A meta-analysis. *Journal of Marital and Family Therapy,* 1-17. doi:10.1111/jmft.12336

Raudenbush, S., & Bryk, A. (2002). *Hierarchical Linear Models (2nd ed.).* London: Sage.

Rheem, K. D. (2011). *Analyzing the withdrawer re-engagement change event in Emotionally Focused Couple therapy: A preliminary task analysis.* (Unpublished doctoral dissertation), Argosy University.

Ridenour, T., Wittenborn, A., Raiff, B., Benedict, N., & Kane-Gill, S. (2015). Illustrating idiographic methods for translation research: Moderation effects, natural clinical experiments, and complex treatment-by-subgroup interactions. *Translational Behavioral Medicine, 6*(1), 125–134. doi:10.1007/s13142-015-0357-5

Ronnestad, M. & Skovholt, T. (2013). *The developing practitioner: Growth and stagnation of therapists and counselors.* New York: Routledge Taylor & Francis Group.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6*(3)*,* 412-415. doi:10.1111/j.1939-0025.1936.tb05248.x

Safran, J. & Muran, J. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology, 64*(3)*,* 447-458. doi:10.1037/0022-006X.64.3.447

Sandberg, J., & Knestel, A. (2011). The experience of learning Emotionally Focused Couples Therapy. *Journal of Marital and Family Therapy, 37*(4), 393–410. doi:10.1111/j.1752-0606.2011.00254.x

Sandberg, J., Knestel, A., & Schade, L. (2013) From head to heart: A report on clinicians' perceptions of the impact of learning Emotionally Focused Couple Therapy on their personal and professional lives. *Journal of Couple & Relationship Therapy, 12*(1)*,* 38-57. doi:10.1080/15332691.2013.750076

Satir, V. (1983). *Conjoint family therapy*. 1st ed. Palo Alto, Calif.: Science and Behavior Books.

Seaburn, D., Landau-Stanton, J., & Horwitz, S. (1995). Core techniques in family therapy. In R. Mikesell, D. Lusterman, & S. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 5-26). Washington, DC, US: American Psychological Association. doi:10.1037/10172-001

Seligman, M. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist, 50*(12)*,* 965-974. doi:10.1037/0003-066X.50.12.965

Sexton, T., Gordon, K., Gurman, A., Lebow, J., Holtzworth-Munroe, A., & Johnson, S. (2011). Guidelines for classifying evidence-based treatments in couple and family therapy. *Family Process, 50*(3), 377-392. doi:10.1111/j.1545-5300.2011.01363.x

Shadish, W., & Baldwin, S. (2005). Effects of Behavioral Marital Therapy: A meta-analysis of randomized controlled trials. *Journal of Consulting and Clinical Psychology, 73*(1), 6-14. doi:10.1111/j.1752-0606.2003.tb01694.x

Shadish, W., & Baldwin, S. (2003). Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy, 29*(4), 547-570. doi:10.1111/j.1752-0606.2003.tb01694.x

Shadish, W., Matt, G., Navarro, A., & Phillips, G. (2000). The effects of psychological therapies under clinically representative conditions: A meta-analysis. *Psychological Bulletin, 126*(4)*,* 512-529. doi:10.1037/0033-2909.126.4.512

Singer, J., & Willett, J. (2003). *Applied longitudinal data analysis: Modeling change and event occurrence.* New York, NY: Oxford.

Smith, M., & Glass, G. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*(9), 752-760. doi:10.1037//0003-066X.32.9.752

Snyder, D., Castellani, A., & Whisman, M. (2006). Current status and future directions in couple therapy. *Annual Review of Psychology, 57,* 317-344. doi:10.1146/annurev.psych.56.091103.070154

Soltani, M., Shairi, M., Roshan, R., & Rahimi, C. (2014). The impact of Emotionally Focused Therapy on emotional distress in infertile couples. *International Journal of Fertility & Sterility, 7*(4), 337-344.

Spanier, G. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and Family Therapy, 38*(1), 15–28. doi:10.2307/350547

Spengler, E., Devore, E., Spengler, P., & Lee, N. (in press). What does "couple" mean in couple therapy outcome research? A systematic review of the implicit and explicit, inclusion and exclusion, of gender and sexual minority individuals. *Journal of Marital and Family Therapy*.

StataCorp. 2017. *Stata Statistical Software: Release 15*. College Station, TX: StataCorp LLC

Tasca, G., & Gallop, R. (2009). Multilevel modeling of longitudinal data for psychotherapy researchers: I. The basics. *Psychotherapy Research: Journal of the Society for Psychotherapy Research, 19*(4-5), 429 – 437. doi:10.1080/10503300802641444.

Timm, T. & Blow, A. (1999). Self-of-the-therapist work: A balance between removing restraints and identifying resources. *Contemporary Family Therapy, 21*(3)*,* 331-351. doi:10.1023/A:1021960315503

U.S. Department of Health & Human Resources (2012). Guidance regarding methods for de-identification of protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule. Retrieved from

https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html

Wampold, B. & Imel, Z. (2015). *The great psychotherapy debate,* 2nd ed. New York: Routledge.

Wiebe, S., & Johnson, S. (2016). A review of the research in Emotionally Focused Therapy for couples. *Family Process, 55,* 390-407. doi:10.1111/famp.12229

Wiebe, S., Johnson, S., Lafontaine, M., Burgess Moser, M., Dalgleish, T., & Tasca, G. (2017). Two-year follow-up outcomes in Emotionally Focused Couple Therapy: An investigation of relationship satisfaction and attachment trajectories. *Journal of Marital and Family Therapy, 43*(2): 227-244. doi:10.1111/jmft.12206

Weissman, N., Batten, S., Rheem, K., Wiebe, S., Pasillas, R., Potts, W.,... Dixon, L. (2017). The effectiveness of Emotionally Focused Couples Therapy with veterans with PTSD: A pilot study. *Journal of Couple & Relationship Therapy: Innovations in Clinical and Educational Interventions, 17*(1), 25-41. doi:10.1080/15332691.2017.1285261

Wittenborn, A. (2012). Exploring the influence of the attachment organizations of novice therapists on their delivery of Emotionally Focused Therapy for Couples. *Journal of Marital and Family Therapy, 38*(1), 50-62. doi:10.1111/j.1752-0606.2012.00290.x

Wittenborn, A., Liu, T., Ridenour, T., Lachmar, M., Mitchell, E., & Seedall, R. (2018). Randomized controlled trial of emotionally focused couple therapy compared to treatment as usual for depression: Outcomes and mechanisms of change. *Journal of Marital and Family Therapy,* doi: 10.1111/jmft.12350

Wood, N., Crane, D., Schaalje, G., & Law, D. (2005). What works for whom: A meta-analytic review of marital and couples therapy in reference to marital distress. *The American Journal of Family Therapy, 33,* 273-287. doi:10.1080/01926180590962147

Zuccarini, D., Johnson, S., Dalgleish, T. & Makinen, J. (2013). Forgiveness and reconciliation in Emotionally Focused Therapy for Couples: The client change process and therapist interventions. *Journal of Marriage and Family Therapy, 39*(2), 148-162. doi:10.1111/j.1752-0606.2012.00287.x

Appendix A - Literature Review

Emotionally Focused Couple Therapy (EFT) is a manualized treatment model with exemplary research support. However, to date, no effectiveness research studies have been conducted to assess outcomes under naturalistic circumstances. This section will briefly introduce the terrain of psychotherapy outcome research, and particularly review the contrasts of efficacy and effectiveness. An overview of Emotionally Focused Couple Therapy and the research support for this therapeutic model introduces the need for effectiveness research for EFT.

Questions of how and how much psychotherapy helps have been explored across years of psychotherapy research. While some debate continues, a balanced scientific approach accepts the convergence of various types and levels of evidence (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006). What constitutes empirical support of psychotherapy has been an unfolding debate, but scientifically measuring impacts of intervention has been practiced for some time. Carefully measured intervention outcomes began with learning-based approaches in the 1920s. In the 1940's researchers taped Rogerian sessions to examine moment-to-moment processes of psychotherapy (Lambert, Bergin & Garfield, 2004). More traditional outcome research began when Rosenzweig (1936) asked if all therapies might be successful for reasons other than what they claimed, based on his findings that all "won prizes", or appeared to have equally successful outcomes. Eysenck (1952) claimed psychotherapy was not more beneficial than no treatment, leading to a plethora of research working to invalidate his claim. A groundbreaking meta-analysis by Smith and Glass (1977) showed, via meta-analytic effect sizes, that 75% of individuals receiving psychotherapy were better off in comparison to an untreated sample. Results indicated overall benefits of

psychotherapy, without indication that one type was better than another (Smith & Glass, 1977). Current review of psychotherapy in general shows it superior to placebo, to wait-list, and to no treatment conditions (Lambert & Ogles, 2004). However, evidence of general effectiveness does not validate specific therapeutic interventions in specific settings with specific clients (Paul, 1967), nor should it promote lackadaisical implementation of whatever methods or combinations practitioners prefer.

With exponential growth of the number of therapy techniques, debates have raged about whether techniques or common factors have more merit (Norcross & Lambert, 2011). The treatment method, randomized controlled trials (RCT), and scientific medical model were pitted against the therapy relationship, effectiveness and process-outcome studies, and the relational-contextual model (Norcross & Lambert, 2011). The official definition of evidence-based practice is the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006, p. 273). Evidence is needed for the effectiveness of therapy in contextual settings, not just laboratory conditions (Leichsenring, 2004). Howard and colleagues provided this framework: (a) Does it work under special, experimental conditions? (e.g., *efficacy*) (b) does it work in practice? (e.g., *effectiveness*) and, further, (c) is it working for this patient? (e.g., *patient-focused*) (1996, p. 1059). Sexton et al. (2011) offer a framework for couple and family psychotherapy research delineated into categories of absolute and relative efficacy/effectiveness, evidence for mechanisms of change, and contextual efficacy, and the expectation that research in each category is needed to provide increasing levels of evidence-based support. EFT is a well-established treatment model with strong support for efficacy in all of these areas. However, limited effectiveness research has been conducted.

Emotionally Focused Couple Therapy

Emotionally Focused Couple Therapy (EFT) is a theoretically grounded, research-based psychotherapy model for couples' counseling (Greenman & Johnson, 2013), developed out of closely reviewing tapes of every day therapy sessions (Furrow, Johnson, & Bradley, 2011) that provides a comprehensive plan of treatment (Wood, Crane, Schaalje, & Law, 2005). EFT as officially premiered in literature in 1985 (Johnson et al, 1995) and presented by Johnson (2004) in the EFT treatment manual, has a foundation in attachment theory, systemic theory, and experiential processing approaches, with an emphasis on repair of bonds in relationships. The principal goal of EFT is to establish and nurture secure attachment between partners. This is accomplished through using in-the-moment emotional experiencing as a medium for change. Explication of underlying theory and implementation of the model is disseminated through ongoing publication on key techniques, providing mini-theories of change processes (Bradley & Furrow, 2004; Zuccarini, Johnson, Dalgleish, & Makinen, 2013), and research on the person-of-the-therapist impacts on treatment outcomes (Furrow, Edwards, Choi, & Bradley, 2012; Wittenborn, 2012). Given the emphasis on integration of theory, research, and practice in counseling psychology, the model's theoretical grounding is an important strength. The theories of attachment, systemic focus, experiential processing of emotions, and emotion regulation are core aspects of the model.

Attachment theory. Understanding of the significance of human connection to healthy functioning has developed out of descriptions of attachment theory first provided by John Bowlby (1988). Bowlby's theory provides a broad conceptualization for close relationships. Attachment theory applied to adult relationships provides a conceptual framework of adult love (Mikulincer & Shaver, 2012) and "offers the couple therapist a focused and integrative

perspective on relationship, a clear set of goals and model of relationship and sexual health, and a map of effective intervention" (Johnson & Zuccarini, 2010, p. 432).

Recent models of attachment, based on theory and interdisciplinary research, suggest attachment system functioning includes a) a primary strategy for general functioning under typical circumstances, b) a strategy for attainment of security, including strategies for achieving a secure intimate relationship, and c) strategies triggered by unavailability of an attachment figure which either hyper-activates or de-activates emotional and subsequent behavioral responses (e.g., strategies employed when attachment is threatened) (Mikulincer & Shaver, 2012). These are related to three behavioral systems activated by need for attachment: Proximity seeking, Distress at separation, and Use of attachment figure as safe haven for distress, caregiving, and sex (in adult attachment relationships) (Mikulincer & Shaver, 2012). Internal schema or strategies of response and management of connection are placed along the dimensions of Approach and Avoidance, resulting in four broad categories: Secure, Anxious, Avoidant, and Disorganized (Johnson, 2004). These categories are descriptive of how persons might typically function in their strategies for attachment and especially under conditions of attachment distress.

When threat or disconnection triggers these behavioral response strategies, attachment styles significantly impact affective experience and resulting behavioral expressions (Johnson & Zuccarini, 2010). The EFT model conceptualizes that unregulated fear in anxious or avoidant responses distorts and blocks requests for attachment, and causes negative patterns of insecurity in relationships (Furrow & Bradley, 2011). Conversely, securely attached adults are able to relatively easily trust others, flexibly regulate and share emotion, and commit to long-term relationships (Mikulincer & Shaver, 2007). This provides a conceptual map for adult attachment and a theoretical framework for relationship distress (Johnson & Zuccarini, 2010).

Systemic theory. Systemic therapy approaches arose out of communication theory, particularly the concept of homeostasis as overtly and covertly maintaining status quo functioning (Satir, 1983). Thus, relational interactions are found to be "repetitious, circular, predictable communication patterns" (Satir, 1983, p.1). From a structural perspective, relational disengagement creates rigid interpersonal boundaries that constrict emotional involvement (Friedlander, Wildman, Heatherington, & Skowron, 1994). Reframing problems as occurring out of circular causality in the system is an essential component of family therapies (Seaburn, Landau-Stanton, & Horwitz, 1995). In EFT as the negative cycles occurring are labeled, and underling emotions and attachment needs understood, a reframe is obtained to explain relationship distress as predictable negative cycles occurring out of unmet attachment needs arising out of relational disengagement (Johnson, 2004). Notably, this relational disengagement may appear as both repetitious attack-attack, attack-withdraw, or withdraw-withdraw behaviors within a relationship (Johnson, 2004). The essential concept of "disengagement" refers not to external withdrawing from the relationship, but an underlying lack of primary emotional bonding and repair that would occur out of secure bids for attachment connections. EFT observes behavior as occurring in a systemic environment, in which behavior is functional within an environment and in which changing one part of the system will influence the system's response (Johnson, 2009). This model approach uses empathic understanding of the systemic pattern of cyclical patterns of distress in the dyadic relationship to de-escalate distress and increase emotional regulation and problem solving flexibility (Johnson, 2004).

Experiential therapy. The underlying tenets of EFT grew out of humanistic experiential perspectives of Carl Roger's client-centered therapy and Fritz Perl's Gestalt therapy (Johnson & Zuccarini, 2010) as well as Process Experiential EFT for individuals (Greenman & Johnson,

2013). Experiential techniques are utilized to increase access, acceptance, and clarity around unacknowledged affective experience (Dunn & Schwebel, 1995). Clients can expand their emotional repertoire through fully experiencing those affective states that are present, but below awareness during problematic interactions. Experiencing underlying emotion in here-and-now experiential moments in EFT facilitates communication of clear attachment messages, to facilitate secure connection with the partner that achieves the comfort and connection previously sought in inflexible communication and behavior, in an experiential manner (Greenman & Johnson, 2013).

Emotion theory. Intra- and inter-personal emotion regulation is viewed as a cornerstone of effective couples therapy (Snyder, Castellani, & Whisman, 2005). Within EFT, emotions are adaptive meaning-making systems (Greenberg, 2008). In the therapeutic process emotions are contextualized, clarified, explored, and heightened in a manner that allows in-session emotional experiencing to develop change (Greenberg, 2008). Bradley and Furrow (2007) describe the task-analyzed blamer-softening change event as both "evidence and example" of the central role of emotions in couples therapy. Johnson (2009) sums up emotion in the relational context, "we deal with basic emotions, engage with others on the basis of these emotions, and continually construct a sense of self from the drama of repeatedly emotionally laden interactions with attachment figures" (p. 410). Secure relationship connection (a sense of connection with a loved one) is a natural emotion regulation device, and absorbing states of distressed affect in close relationships may have deleterious effects. Emotional processing in session slows down reactive affective attachment responses, integrates them with associated thoughts and behaviors, and transforms relational patterns (Johnson & Zuccarini, 2010).

A key aspect of this approach is distinguishing primary and secondary emotions, and the way these emotions impact couples' interactional cycles. Secondary emotions are reactive, and according to Greenberg (2008) obscure underlying primary emotions. Primary emotions contain adaptive information and organize action (Greenberg, 2008), but tend to be more vulnerable and highlight inter-dependence. Thus in moments of distress and disconnection, primary emotion is more risky to access and share. Particularly in distressed individuals or relationships, psychological defenses may allow for avoiding or hiding primary emotions and related attachment bids (Greenberg, 2008). A body of literature is available for methods of working with primary and secondary emotion in psychotherapy (Greenberg, 2008; Greenberg & Pascual-Leone, 2006). These processes are designed to develop awareness and flexible regulation of emotional experience, thus avoiding the pitfalls of over- or under-regulation of emotion (Greenberg, 2008). Many EFT interventions are designed to track, increase awareness of, expand, and transform emotional experience (Johnson, 2004).

Sequential model of intervention. Putting these concepts together, as behavioral interactions are tracked in their systemic, cyclical patterns, underlying schema and reactive emotions are linked to primary emotions and affect arising out of attachment needs (Johnson, 2004). This is consciously used to reframe behaviors as occurring in a dynamic, interactive attachment-rich context. Increased ownership of attachment needs and a changing perception of self and other occur out of this experiential exploration (Dunn & Schwebel, 1995). Deeper emotional awareness and sharing, and subsequent deepening and restructuring of attachment bonds are achieved through iterative processes and sequential tasks in therapy. The model follows 3 Stages and 9 Steps outlined by Johnson in the treatment manual (Johnson, 2004). These stages and steps include:

Stage 1. Cycle de-escalation

1. Assessment: Creating an alliance and explicating the core issues in the marital conflict by using an attachment perspective.

2. Identifying the problematic interactional cycles that maintain attachment insecurity and marital distress.

3. Accessing the unacknowledged emotions underlying interactional patterns.

4. Reframing the problem in terms of the cycle, the underlying emotions, and attachment needs.

Stage 2. Restructuring Interactional Patterns (Softening and Re-engaging Change Events)

5. Promoting identification with disowned needs and aspects of self and integrating these into relationship interactions

6. Promoting acceptance of the partner's new construction of the relationship and new interactional behavior

7. Facilitating the expression of specific needs and wants

Stage 3. Consolidation

8. Facilitating the emergence of new solutions to old relationship problems

9. Consolidating new positions and new cycles of attachment behavior

The therapeutic model has an established set of general interventions, including: Alliance building/monitoring, Empathic conjectures, Evocative responding, Heightening present and changing relationship positions, Validation of client responses, and Reframing (of cycle, of attachment needs) (Johnson, 2004). Further, there are structures for smaller interventions within the model, particularly for facilitation of blamer-softening sessions. This includes: Processing possible blamer reaching, Processing fears of reaching, Promoting actual blamer reaching,

Supporting softening blamer, Processing with engaged withdrawer, and Promoting engaged withdrawer reaching back with support (Bradley & Furrow, 2004). Through these interventions, distress in close relationships is reframed as predictable negative cycles occurring out of unmet attachment needs (Johnson, 2004). These cycles can be labeled, underlying emotions and attachment needs clarified, and behavior framed as functional within an environment in which changing one part of the system will influence the system's response. Research of the processes, clear description the model, and evidence of positive clinical outcome makes it available for use as an empirically supported model (Furrow, Johnson & Bradley, 2011).

Overview of Research in EFT

EFT is one of two theoretically based, manualized, and empirically validated approaches to couple therapy (the other is Behavioral Couples Therapy) (Byrne, Carr & Clark, 2004; Johnson & Greenman, 2013). While RCTs have established the clinical validity of this approach (Johnson, Hunsley, Greenberg, & Schindler, 1999), process research on EFT solidifies theoretical hypotheses of deepening of emotion and therapeutic alliance (Furrow et al., 2011). EFT has been the focus of two meta-analytic reviews (Johnson et al., 1999; Lee, Spengler, Wittenborn, & Wiebe, 2019) and compared to other approaches in three meta-analyses of couple therapy outcomes (Dunn & Schwebel, 1995; Rathgeber, Burkner, Schiller, & Holling, 2018; Wood et al., 2005). Finally, various client and therapist variables have been considered in studies of this approach. The following is an overview of these various aspects of the empirical evidence for EFT.

A meta-analysis of only EFT studies (Johnson et al., 1999) reviewed several outcome studies and selected the most clinically rigorous for meta-analysis. Using Jacobson and Truax's (1991) criteria for assessing significantly clinical change, Johnson et al., (1999) found a mean

effect size (*d)* of 1.31 for the implementation of EFT compared to no treatment. At that time, all studies included treatment integrity via checks on tapes of therapy sessions and all had very low attrition rates, indicating high internal validity (Johnson et al, 1999). This comparatively high effect size is an early estimate, and is not reflected in later studies. Labeled as an insight-oriented marital therapy (IOMT) approach, EFT was compared to behavioral marital therapy (BMT) and cognitive-behavioral marital therapy (CBMT) (Dunn & Schwebel, 1995). All approaches were found to be significantly effective compared to untreated controls, but comparison of the relationship measures post-treatment for the experimental and control groups found a mean Glass' effect size for IOMT approaches of $\Delta = 1.37$, compared to 0.78 for BMT and 0.71 for CBMT (Dunn & Schwebel, 1995). Glass's effect size, which divides mean differences by the standard deviation of only the control group, in contrast to the pooled standard deviation used in a Cohen's *d* estimation, provides a more conservative estimate of effects (Dunn & Schwebel, 1995). A later comparison of EFT to BMT tentatively concluded clinical trials of EFT showed significantly more effective results for treating moderate marital distress (Wood et al., 2005). Wood et al., (2005) attributed this to the comprehensive treatment approach provided by EFT. A meta-analysis comparing Behavioral Couple Therapy (BCT) and EFT found an overall effect size of $g = 0.60$, with an effect size for EFT of $g = 0.73$ (Rathgeber et al., 2018). A current and comprehensive analysis of all extant EFT outcome research at this time estimates an effect size of $d = 0.98$ (Lee et al., 2019). Although variation in findings is present, all meta-analytic results place EFT at the forefront of couple therapy approaches with strong empirical support.

EFT Outcome Studies

Efficacy. Several RCT outcome studies of EFT have been conducted with randomly assigned groups for comparison to other treatments and waitlist controls. The first two published

studies of EFT are examples of absolute and relative efficacy evidence. An initial study of EFT as a treatment model assessed couples before an 8-week waiting period, prior to treatment, after 8 weeks of treatment, and 8 weeks following the completion of treatment (Johnson & Greenberg, 1985a). The within-subjects analysis showed significant changes at the 8-week follow up assessment (Johnson & Greenberg, 1985a). These findings have been replicated in other comparisons to wait-list controls, conducted by researchers not associated with the creation of the model, with comparable results (Denton, Burleson, Clark, Rodriguez, & Hobbs, 2000). Denton, Burleson et al., (2000) conducted an experimental comparison study between a control group and an experimental group in partial replication of Johnson and Greenberg (1985a). The impact of 8 sessions of EFT for couples was measured through pre- and post-intervention observations with clinically significant results in comparison to the wait-list control group. Johnson and Greenberg's (1985b) comparison of EFT to CBT, a problem-solving instruction intervention, and a wait-list group exemplifies relative efficacy. Results indicated better outcomes for the EFT group as measured by the Dyadic Adjustment Scale (DAS) and Personal Assessment of Intimacy in Relationships scale (PAIR) (Johnson & Greenberg, 1985b). Other studies have compared EFT to Cognitive Marital Therapy (Dandeneau & Johnson, 1994), and to Integrated Systemic Therapy (Goldman & Greenberg, 1992). When compared to Cognitive Marital Therapy (CMT), EFT had better results at follow-up (Dandeneau & Johnson, 1994). EFT with an added communication-training component was compared to EFT treatment as usual, with no differential treatment effects, except greater satisfaction with EFT treatment as usual at 2 and 4 month follow up point (James, 1991). EFT has better outcomes than no-treatment controls, and at least equivalent outcomes to comparison treatments. Long-term follow-up studies at two-

and three-years show maintenance of therapeutic gains (Clothier, Manion, Gordon-Walker, & Johnson, 2002; Halchuk, Makinen, & Johnson, 2010).

Contextual efficacy. Sexton et al. (2011) defines contextual efficacy as the degree to which an intervention is efficacious in varying community contexts. Several studies have examined the generalizability of EFT for certain diagnoses and comorbid conditions. Dessaulles (1991) conducted a study of 18 couples in which the female met full criteria for depression, comparing dyadic treatment to individual pharmacotherapy. Females in the EFT condition had higher and clinically significant outcomes for both marital adjustment and depression, although only two couples met criteria for "recovered". While these studies address the generalizability of EFT to specific conditions, they are conducted under highly controlled conditions, and thus have limited generalizability to routine clinical settings. EFT for females with inhibited sexual desire (ISD) found modest treatment differences in comparison to a non-ISD control group (McPhee, Johnson & Van der Veer, 1995). Clinical improvements were found in a study of the efficacy of EFT applied to couples with a chronically ill child (Gordon-Walker, Johnson, Manion & Cloutier, 1996).

Other studies have attended to specific demographics. In research with couples where one partner had PTSD from childhood sexual abuse (CSA), survivors had clinically significant decreases in PTSD symptoms on the Trauma Symptom Inventory (TSI) and Clinician Administered PTSD scale (CAPS) for at least half of participants after an average of 19 sessions (MacIntosh & Johnson, 2008). EFT for couples with war veterans resulted in significant decreases in veterans' PTSD symptoms after an average of 30 sessions (Weissman et al., 2017). Symptoms of PTSD among women with breast cancer had clinically significant reduction after a course of EFT in comparison to a control group (Naaman, Radwan, & Johnson, 2008). After an

average of 20 sessions of EFT for couples, women with trauma symptoms from childhood abuse had notable reductions in symptoms in comparison to control conditions (Dalton, Greenman, Classen, & Johnson, 2013).

Several studies have attended to specific diagnoses or conditions. Comparison to individual psychopharmacology treatment of depression over a six month period (Denton, Wittenborn, & Golden, 2012) and efficacy of EFT when one partner is diagnosed with depression (Dessaulles, Johnson, & Denton, 2003) had promising results for the treatment of depression, although relationship satisfaction did not improve. Studies with female survivors of childhood abuse (CSA) had a 70% recovery rate and self-reported reduction in trauma symptoms (Dalton et al., 2013; MacIntosh & Johnson, 2008). Studies of couples impacted by medical concerns, including couples with a female partner with breast cancer (Couture-Lalande, Greenman, Naaman, & Johnson, 2007; McLean, Walton, Rodin, Esplen, & Jones, 2013) and couples with chronically ill children (Gordon-Walker, Johnson, Manion, & Cloutier, 1996) give evidence of success applying EFT to certain client-specific conditions. Follow up on a 63% recovery rate in a study attending to resolution of specific emotional injuries within the relationship, indicated successful treatment took longer than the brief 8-12 sessions typically recommended (Makinen & Johnson, 2006). The lowest benefits of all published EFT studies were reported in a study of low sexual desire in women, in which brief treatment only somewhat benefited the participating couples (McPhee et al., 1995). However, long-term efficacy follow-up studies via a two-year follow up of couples with chronically ill children (Clothier et al., 2002) and three-year follow-up of couples with specific attachment injury during treatment (Halchuk et al., 2010) indicated continued improvement and prevention or relapse beyond average results of all couple therapy approaches. In sum, outcome studies of EFT show EFT to be comparable or

better than other empirically supported treatments. Existing research provides evidence for EFT as efficacious for the treatment of relationship distress under certain conditions.

Task Analysis Studies

Hypothesized active ingredients in therapy models are tested to determine whether theorized mechanisms of change are linked to successful outcomes (Sexton et al., 2011). An early study relating process to outcome, highlighted "best sessions" of successful EFT treatments, to confirm the blamer-softening change event as a necessary part of the model (Johnson & Greenberg, 1988). Softening of a blaming-pursing partner is found to be an essential element of successful treatment (Bradley & Furrow, 2007), and has been task-analyzed to map the sequential interventions of this change event (Bradley & Furrow, 2004; Bradley & Johnson, 2005). Task analysis of successful resolution of attachment injures resulted in the Attachment Injury Resolution Model, and linked this successful resolution to better post-treatment outcomes (Makinen & Johnson, 2006). Two studies have examined the tasks and steps of the withdrawer re-engaging event (Lee, Spengler, Mitchell, Spengler, & Spiker, 2017; Rheem, 2011). Additional studies have been conducted on in-session change (Greenberg, Ford, Alden, & Johnson, 1993) and predictors of successful treatment (Johnson & Talitman, 1997) to further explore and describe the key ingredients of this model. The depth of analysis for the process of this model is unique within research of psychotherapy approaches.

Notably, an fMRI imaging study provided evidence that EFT treatment impacts neuropsychological functioning in line with theoretical predictions (Johnson et al., 2013). This study tested whether a couple's ability to regulate each other's neural responses is increased by EFT intervention, as would be hypothesized by the theorized impact of creating attachment security in an attachment relationship (Johnson et al., 2013). To test the hypothesis, female

participants had fMRI images taken of their brains while under threat of electric shock. The conditions of holding the hand of one's partner, holding the hand of a stranger, and no hand holding were compared prior to treatment and following engagement in a full EFT treatment. Johnson et al. (2013) found that EFT treatment did indeed increase the neurological regulation provided by holding one's partner's hand. Furthermore findings suggest self-regulation was enhanced as well (Johnson et al., 2013). This research represents an important step forward in research of psychotherapy in general, and couple therapy in particular. These studies have considered what aspects of the treatment package are essential and what specific client-therapist sequences facilitate critical events for successful change and long-term outcomes, and offer evidence validating the hypothesized mechanisms of change for this treatment.

Studies of Therapist Functioning

The role of the therapist in outcomes has recently been given attention in EFT research. Therapists' abilities to focus, engage, heighten emotional experience, and facilitate powerful attachment-focused enactments are essential to successful EFT treatment (Bradley & Furrow, 2007). The role of the therapist has been attended to via tracking therapist presence in EFT change events (Furrow et al., 2012). A model fidelity scale has been created, but does not have validity or reliability information (Denton, Johnson, & Burleson, 2009). Surveys of the effects on the therapist of learning EFT (Montagno, Svatovic, & Levenson, 2011) and clinicians' perceptions of the impact of learning EFT (Sandberg, Knestel, & Schade, 2013) are seeking to understand therapist developmental processes in EFT. Finally, emerging research is analyzing the influence of therapist attachment style on treatment outcomes (Wittenborn, 2012). These studies are representative of new developments in research on therapist variables in EFT and few conclusions can be drawn from these studies without replication and additional evidence.

EFT has exemplary research considering treatment outcome, change processes, client and therapist variables, and even tests of neurological outcome. Overall, 70%-73% of couples recover, 86-90% have significant increases in relationship satisfaction, and effects are maintained over time (Johnson et al., 1999; Halchuk et al., 2010). However, all outcome studies to date have been conducted under highly controlled conditions and there remains a gap in the applicability of this research to daily practice.

Efficacy and Effectiveness

Randomized controlled trials (RCT) have been the "golden standard" for evidence-based treatment, but dissatisfactions with the research-practice gap have abounded, and calls for more clinically representative research have been issued (Leichsenring, 2004; Sexton et al., 2011). Effectiveness methods have been like a "younger sibling" that must prove it can meet the standards of efficacy methods. However, this has resulted in inappropriate and unhelpful comparison. While RCTs are needed to demonstrate specific therapeutic effects; effectiveness research answers the question, "Does it work in practice?" (Leichsenring, 2004).

Leichsenring (2004) compares research therapy (laboratory) vs. clinical therapy (field) characteristics, contrasting non-referred populations, specially trained therapists, small caseloads, and exclusion of comorbidity vs. clinical populations, variously trained and less-supervised therapists, full caseloads, and complexity of presenting problems. The defining feature of RCTs is random assignment of subjects to different treatment conditions, with a therapy group compared to control condition (wait-list of placebo) or to an already established therapy. Use of therapy manuals and treatment of a specific disorder are required (Leichsenring, 2004). Randomization theoretically provides high internal validity and ability to attribute the effects to the intervention. When a therapy has research support in a controlled setting, then it may be

applied in clinical practice, "on the assumption that it works equally well in the field" (Leichsenring, 2004, p. 140).

This assumed bridge to field applications has been questioned (Shadish, Matt, Navarro, & Phillips, 2000). What evidence shows psychological therapies work under clinically representative conditions? Is the efficacious treatment transportable to a clinical setting? Artificial conditions not representative of clinical practice weaken the external validity of RCTs (Leichsenring, 2004). The clinical trial research conditions do not account for practice modifications, longer amounts of time spent in treatment, and modifications of therapy treatment decisions made by practitioners (Leichsenring, 2004; Shadish et al. 2000). RCTs and naturalistic studies are both needed, and naturalistic studies are not lower forms of evidence (Leichsenring, 2004).

Effectiveness Research Methodology

A primary challenge of effectiveness research is defining the conditions of an effectiveness study such that it can be considered a reliable and valid study without laboratory controls. Quality effectiveness methodology has been delineated (Leichsenring, 2004). Three approaches address concerns regarding the validity and usefulness of effectiveness treatments. First, effectiveness is accepted as a different, but complimentary methodology to RCTs. Second, threats to internal validity are addressed by carefully defining the goals of the study and designing the methodology in a manner that meets those goals (Leichsenring, 2004; Shadish et al., 2000). That is, effectiveness research methods arise out of the goals of effectiveness research, not to satisfy the goals of randomized clinical trials (Nathan, Stuart, & Dolan, 2000; Sexton et al., 2011). Finally, benchmarking is used as a bridge between laboratory and naturalistic studies (Minami, Wampold, Serlin, Hamilton, & Brown, 2008).

Effectiveness as a complimentary approach. Defined by randomly assigned groups, efficacy studies are the quintessential experimental design (Heppner, Wampold, & Kivlighan, 2008). RCTs use artificially recruited participants, rather than using clinical populations seeking treatment, have stringent inclusion criteria, and therapists are typically highly trained and supervised (Leichsenring, 2004). Effectiveness research is defined by high clinical representativeness, with treatment-seeking populations, allowing case complexity, and treatment as usual, without special supervision (Heppner et al., 2008; Shadish et al., 2000). Effectiveness studies are client focused; instead of statistically significant change, clinically significant and reliable changes are of greater interest (Nathan et al., 2000). Finally, effectiveness studies include both specific measures of the target variable and general measures of overall improvement (Nathan et al., 2000). Although quality effectiveness research is highly representative of clinical conditions to ensure generalizability, this does not preclude internal validity (Leichsenring, 2004)

Enhancing the validity of effectiveness research. The validity of effectiveness research is enhanced by clearly specifying the methods of the study, in particular who was included and what was implemented and measured (Shadish et al., 2000). Clarity of information about participants, treatment, and detail about the circumstances – length of treatment, time of treatment, cost, and any other significant influences is needed (Leichsenring, 2004). In place of methodological control, statistical controls are implemented (Shadish et al., 2000). Multiple converging and diverging measures, modeling change over time, and comparing nonrandom groups through stratification offer statistical controls to compensate for lack of manipulation of study elements (Leichsenring, 2004). Finally, effectiveness studies use comparison of outcomes

to previously found outcomes in highly controlled studies as a method evaluating the validity of findings in the uncontrolled study via benchmarking.

Using benchmarking as an outcome tool. Benchmarking is a relatively new method of bridging research and practice (Minami, Serlin et al., 2008). Benchmarking, in its most basic form, consists of establishing standards from aggregated data from representative RCTs or relevant meta-analytic reviews that serve as comparisons for acceptable levels of effectiveness outcomes. Because effect sizes only provide information about those who completed treatment, consideration of the percentage of patients who dropped out, who completed treatment, and who were reliably improved at termination are used as additional comparison points (Hunsley & Lee, 2007). In the present study, benchmarking will be used to compare the effectiveness outcomes to clinical trial outcomes of EFT studies.

Since the establishment of greater methodological rigor for psychotherapy research, efficacy research has enjoyed the limelight, and is certainly necessary to establish the safety and impact of treatment approaches. However, as the field matures, and as research develops for various approaches, methodological plurality is needed (Leichsenring, 2004; Sexton et al., 2011). Allowing efficacy and effectiveness research to inform each other, increasing the methodological rigor of effectiveness research by attending to methods of controlling internal validity, and using benchmarking as a bridge between the two are considered best practices in outcome research. All of these methods are considered in the current study.

Strengths and Weaknesses of Effectiveness Research

A primary challenge of effectiveness research is defining the conditions of an effectiveness study such that it can be considered a reliable and valid study without laboratory controls. While the current study utilizes suggested methods for minimizing threats to validity,

some limitations are unavoidable. Internal validity refers to the strength to which conclusions can be made about the covariation of treatment and outcome reflecting a causal relationship (Shadish et al., 2000). Without comparison of randomly selected groups the study does not rule out extraneous explanations, such as history and maturation. Events concurrent with treatment and naturally occurring changes over time could have unknown impacts. The study does not provide evidence that the intervention is the cause of the changes in outcome.

Measuring and enforcing therapists' fidelity to the model is necessary in RCTs to establish reception of equivalent dosages of treatment. Under real world conditions, other than therapists' intentions to provide a particular intervention, there are no tests of treatment adherence. Increased probability of type II error is present, due to increased variability in the sample, and decreased restrictions on study participants. These are the costs of having a clinically representative study. The primary strength of effectiveness research is generalizability of the findings. External validity refers to applicability of findings across units, treatments, outcomes and settings (Heppner et al., 2008).

Person and Relationship Variables

Psychotherapy outcome literature includes common factors such as the therapeutic relationship, consideration for therapist and client variables, and the impact of the evidence based practice (EBP) movement. While these factors are not directly considered in efficacy and effectiveness studies, the importance of these variables to outcomes is increasingly being considered (Heppner et al., 2008; Wampold & Imel, 2015). Working alliance, therapist, and client variables are briefly reviewed here.

Relationship. The therapist-client relationship is the largest common factor in psychotherapy and accounts for a large percentage of therapy outcomes (Messer & Wampold,

2002). Likely the most studied common factor in outcome research (Orlinsky, Ronnestad, & Willutski, 2004), research on the working alliance suggests the quality of the therapeutic alliance is one of the more reliable predictors for outcome (Safran & Muran, 1996). The presence of a working alliance is often either assumed or ignored in efficacy and effectiveness research. EFT has a history of including a working alliance measure in outcomes studies (e.g., Johnson & Greenberg, 1985a). Studies of variability in the alliance attribute better working alliance scores to therapist skill (Baldwin, Wampold, & Imel, 2007).

Therapist Variables. Historically outcome studies have indicated no difference in effectiveness of treatment as a function of therapist expertise (Lambert et al., 2004). Specifically, research findings suggested no significant differences between highly trained professionals' and novice therapists' outcomes, leaving the value of training and experience in question (Lambert et al., 2004). In contrast, Ronnestad and Skovholt's (2013) synthesis of psychotherapy research calls for attention to therapists' contribution to the alliance and overall psychotherapy outcomes. Family therapy literature has a long tradition of attention to the person of the therapist (POTT). Timm and Blow (1999) proposed that this personal awareness training in family therapy distinguished between mediocre therapists and excellent therapists. An estimated 5-8% of the variance in outcomes is due to therapist effects (Kim, Wampold & Bolt, 2006).

In RCTs treatment adherence has been privileged above therapist differences, with therapist skill being considered a constant, if adherence criteria are met. Findings suggest competence, rather than adherence had a greater association with treatment outcome (Barber, Crits-Christoph & Luborsky, 1996). Therapist competence is defined by Heppner et al., (2008) as therapists who have better than average outcomes. Therapist competence can be analyzed as a random factor (Wampold & Imel, 2015). In addition to measures of the therapeutic alliance as a

test of therapist effectiveness (Johnson & Greenberg, 1985a), multi-level modeling is recommended to account for therapist differences (Heppner et al., 2008). Future consideration of therapist variables could provide additional information about training and expertise within this particular model given the tiered level of expectations across training levels.

Client Variables. The highest percentage of outcome is attributed to clients' contribution to their own change. The client's contribution is estimated to account for about 87% of change, suggesting 13% of change occurs because of therapy (Duncan, 2010). Patient profiling or patient focused research measures a the specific question, "Is this patient's condition responding to the treatment that is being applied?" (Howard et al, 1996, p. 1060). This angle of measurement allows outcome observations to account for the variety of client variables potentially impacting successful outcome. Increasingly, these variables are considered in discussion of evidence-based practice, although third party reimbursement procedures do not yet reflect this. In the current study client variables are not directly researched. As an effectiveness study collecting naturally occurring therapy data, client variables are less restricted than would typically occur in efficacy research.

In summary, therapist and client variables have demonstrably significant impacts on therapy outcome, particularly through their contributions to alliance as a common factor in treatments. Now more than ever, scientific enquiry must give evidence of the relevance of an intervention in actual use. While third party reimbursement tends to rely on evidence produced by randomly controlled trials, practitioners attempting to implement these models in daily practice rely on information about what a model looks like naturally. While all of these variables are important, a single study cannot account for all aspects once. The present study considers the

outcomes of EFT for couples as implemented in daily practice with limited restrictions on client demographics or presenting problems.

An Effectiveness Study of EFT

EFT has empirical support via RCT studies and in-depth research on key mechanisms of change process. Are these results generalizable to naturally occurring clinical settings? In addition to efficacy studies, studies of client and therapist variables, and studies of common factors, effectiveness research provides vital information about therapy in every day practice. As a manualized treatment with rigorous training available, Emotionally Focused Couple Therapy lends itself to being measured in applied settings. The systematic research conducted on EFT has demonstrated efficacy but has not yet supported its effectiveness in natural settings without carefully monitored model adherence, high levels of supervision and low caseloads. In prior research of EFT, intensive supervision is present, which hypothetically enhances treatment outcome since high adherence to the treatment model is maintained. For most practicing therapists "in the trenches" doing couple therapy with this level of supervision is not available or practical. Regardless of how effective expert or carefully monitored therapists can be with a therapeutic model, the majority of therapy is conducted outside of this expert environment. A robust model of psychotherapy will sustain the translation from laboratory to "real world" application. This leads to the present question: Do practicing EFT therapists in natural settings have client outcomes statistically similar to those found in RCTs? Specifically, when clients' initial distress, change across treatment, and final treatment outcome data are measured in a natural environment and without study-specific supervision, is the effectiveness similar to prior effect sizes found in RCT trials? Research and literature on EFT has incorporated the elements of therapist and client variables. A body of outcome research has established EFT as efficacious,

and thus able to be used as an evidence-based practice. Research on the effectiveness of EFT will offer a key piece of outcome evidence in the body of EFT research support, and will offer additional support for therapists implementing the model in their every day practice.

Appendix B - Emotionally Focused Therapy Training Levels Defined

EFT therapists' training levels can vary across 5 categories: Externship, Core Skills/Advanced Externship, EFT Certified Therapist, EFT Certified Supervisor, and EFT Certified Trainer. Specific standards for EFT training levels can be reviewed at the ICEEFT website (www.iceeft.com). *Externship* training includes four consecutive days of eight hours of training. This training is facilitated by Certified EFT Trainers and includes instruction on the theory and practice of the model, viewing taped and live sessions, engaging in role-plays, and group discussion. At the next level, trainees complete either *Core Skills* training, 48 hours of training over four, two-day workshops, or *Advanced Externship*, which includes 24 hours of training and 24 hours of group supervision. These involve intensive instruction, viewing videos, and role-play. Additionally each participant is required to show video of their own work and receive group supervision on their implementation of EFT. *Certified EFT Therapists* must have completed both levels of training, have eight hours of individual supervision with a Certified EFT Supervisor, and meet the following prerequisites: a post graduate degree in a relevant discipline, membership in a recognized professional association, such as the American Association for Marriage and Family Therapy (AAMFT), current engagement in clinical therapy practice that includes treatment of couples and families, a license to practice psychotherapy in their state/province, proof of malpractice insurance, completion of two graduate courses on the practice of couples and family therapy, and membership in ICEEFT. Applications include submission of an overview of training experiences, curriculum vitae, letters of reference, and a detailed case presentation with two videos exemplifying key interventions in Stage 1 and in Stage 2. Application for certification as a *Certified EFT Supervisor* includes certification as an EFT Therapist for one year, ten hours of mentorship from Certified EFT Supervisors/Trainers,

completion of a course on supervision, four years of clinical experience with couples and families, supervision of a minimum of three therapists in EFT training, a written description of experiences in supervision, two recordings demonstrating supervision, and two reference letters from mentors of supervision. *ICEEFT Trainers* are previously Certified EFT Supervisors who have the endorsement of two other EFT trainers that are willing to act as mentors as the trainer learns the responsibilities of teaching, supervising, developing, and promoting the EFT model. Proposals are reviewed by the ICEEFT Education Committee and/or the Board of Directors, with decisions being made on the basis of the potential contribution of the candidate to EFT training as a whole, the overall priorities of ICEEFT, and perceived need for additional trainers.

Appendix C – Tables

Table 1

Therapist Characteristics

Therapist	Licensure	Years Experience	Years EFT Experience	EFT Training Level	EFT Supervision/Review
1	Psychologist	27	8	Certified therapist	12
2	LCSW	10	3	Core Skills	5
3	LMFT	9.5	5	Core Skills	29
4	LMFT, LCMFT	22	11	Certified therapist	29
5	Psychologist	17	2	Core Skills	3.5
6	Psychologist	36	6	Certified therapist	1.75
7	LCSW	28	13	EFT Trainer	13

Note. EFT Supervision/Review indicates an estimate of average hours per week spent in EFT supervision or review of cases or video. LCSW = Licensed Clinical Social Worker; LMFT = Licensed Marriage and Family Therapist; LCMFT = Licensed Clinical Marriage and Family Therapist.

Table 2

Couple Characteristics

Couple	Sessions	Missing Data	Treatment Status	Stage	Reliable Change Index
1	9	2	Continuing in Treatment[a]	Stage 1	IF improved, IF deteriorated
2	22	0	Completed Treatment	Stage 3	RS improved, IF improved (2)
3	6	0	Ended Treatment [a]	Stage 1	
4	30	8	Continuing in Treatment	Stage 2	
5	12	0	Continuing in Treatment	Stage 2	
6	5	4	Early Termination [b]	Stage 1	
7	6	2	Early Termination [b]	Stage 2	
8	11	0	Early Termination [b]	Stage 2	IF improved
9	14	8	Completed Treatment	Stage 3	IF deteriorated
10	5	0	Completed Treatment	Stage 3	IF deteriorated
11	22	10	Continuing in Treatment	Stage 1	RS improved (2), IF improved, IF deteriorated

Note. Missing data indicates total number of missing data points within the couple. Reliable change reflects improvement or deterioration of 12 points in relationship satisfaction and a change of 10 points for individual functioning. IF = Individual Functioning; RS = Relationship Satisfaction. [a]Couple separated. [b] Couple stopped treatment prior to therapist recommendation.

Table 3

Clinical Groupings and Reliable Change Outcomes

	Starting in clinical range	Starting in healthy range	Ending in clinical range	Ending in healthy range	Reliably improved	Reliably deteriorated
Relationship Satisfaction[a]	13	9	7	15	3	0
Individual Functioning[b]	3	19	2	20	6	4

Note. [a]Measured by the Revised Dyadic Adjustment Scale. A score of 48 or above is considered in the non-clinical range, with higher scores indicating better adjustment. Reliable change index is 12 points. [b]Measured by the Outcome Questionnaire 30.2. A score of 43 or below is considered to be in the non-clinical range, with lower scores indicating better adjustment. Reliable change index is 10.

Table 4

Mixed Multilevel Model Comparisons for Relationship Satisfaction

		Model A	Model B	Model C	Model D
Fixed Effects					
Initial Status,	Intercept	46.98	45.52	45.00	49.86
		(1.24)	(1.35)	(1.44)	(1.80)
Time	Intercept		0.21	0.31	0.27
			(0.04)	(0.10)	(0.09)
Individual Functioning	Intercept				-0.15
					(0.03)
Variance Components					
Level 1	Within-person	18.22	16.52	12.46	11.54
		(1.63)	(1.49)	(1.16)	(1.07)
Level 2	In initial status	6.47	6.56	7.10	6.71
		(3.40)	(3.38)	(4.15)	(3.90)
	In rate of change			0.10	0.07
				(0.05)	(0.04)
Level 3	Within couples	12.48	14.93	17.27	19.20
		(7.38)	(8.39)	(9.73)	(10.36)
Goodness-of-Fit and Model Comparison					
	Likelihood ratio $\chi 2$		22.68	45.31	21.64
			($p < 0.001$)	($p < 0.001$)	($p < 0.001$)
	AIC	1589.796	1569.114	1525.802	1506.167
	BIC	1604.145	1587.050	1547.326	1531.278
	ICC COUPLE	.336 (.143)	.393 (.146)	.470 (.160)	.513 (.154)
	ICC ID/COUPLE	.511 (.100)	.566 (.099)	.663 (.092)	.692 (.088)

Note. STATA, ML. Model A Unconditional means model, Model B Unconditional Growth Model, Model C - Time as a Random Effect, Model D - Time and OQ as Random Effects.

Table 5

Mixed Multilevel Model Comparisons for Individual Functioning

		Model A	Model B	Model C	Model D	Model E
Fixed Effects						
Initial Status	Intercept	30.72	32.25	30.72	32.25	32.23
		(2.40)	(2.49)	(2.36)	(2.44)	(2.19)
Rate of	Intercept		- 0.22		-0.22	-0.21*
Change			(0.07)		(0.07)	(0.18)
Variance Components						
Level 1	Within-person	50.67	48.85	50.67	48.85	40.80
		(4.57)	(4.41)	(4.57)	(4.41)	(3.82)
Level 2	In initial status	113.28	113.65	116.80	119.08	91.45
		(50.11)	(50.20)	(36.41)	(37.05)	(30.47)
	In rate of change					0.34
						(0.19)
Level 3	Within couples	3.51	5.41			
		(36.47)	(37.10)			
Goodness-of-Fit						
	Likelihood ratio $\chi 2$		8.77	---	8.59	36.85
			($p < 0.01$)		($p < 0.01$)	($p < 0.001$)
	AIC	1883.941	1877.342	1881.950	1875.364	1849.097
	BIC	1898.290	1895.278	1892.712	1889.713	1867.033
	ICC COUPLE ICC	.021 (.218)	.032 (.220)			
	ID/COUPLE	.697 (.069)	.709 (.067)	.697(.069)	.709(.067)	.691(.074)

Note. STATA, ML. Model A Unconditional means model, Model B Unconditional Growth Model, Model C Unconditional Means Model with Couples Level removed, Model D Unconditional Growth Model with Couples Level removed, Model E Unconditional Means model with covariance of time at between individual level; *not significant.

Table 6

Pre-posttest Measure Comparisons and Effect Sizes

	Baseline, mean (SD)	Posttreatment, mean (SD)	Cohen's *d*	Paired *t*-tests		
				df	*t*	*p*
Relationship Satisfaction	44.36 (6.91)	47.77 (6.04)	0.46	21	2.566	.018
Individual Functioning	31.82 (11.10)	29.41 (13.79)	0.21	21	1.103	.282

Appendix D

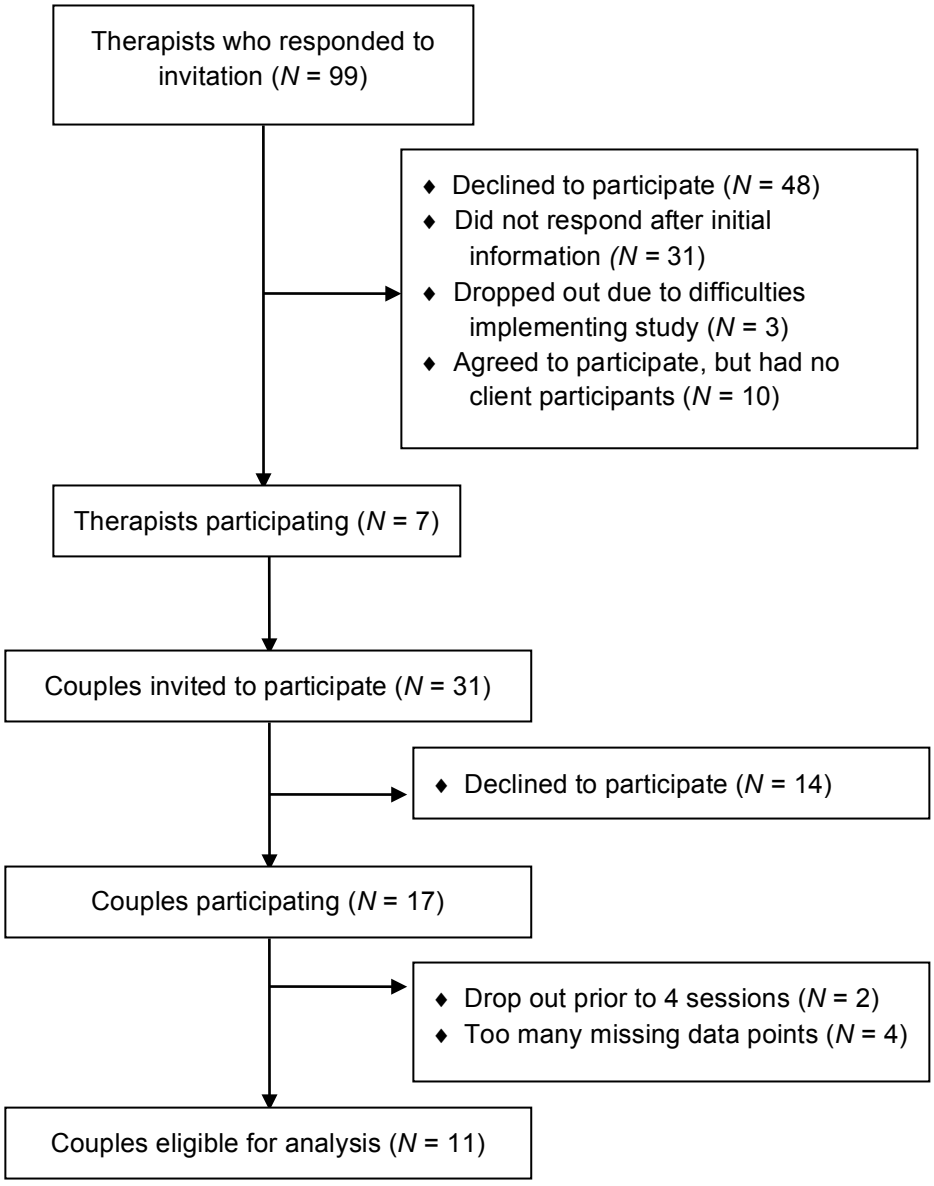

Figure 1. Recruitment flow diagram.

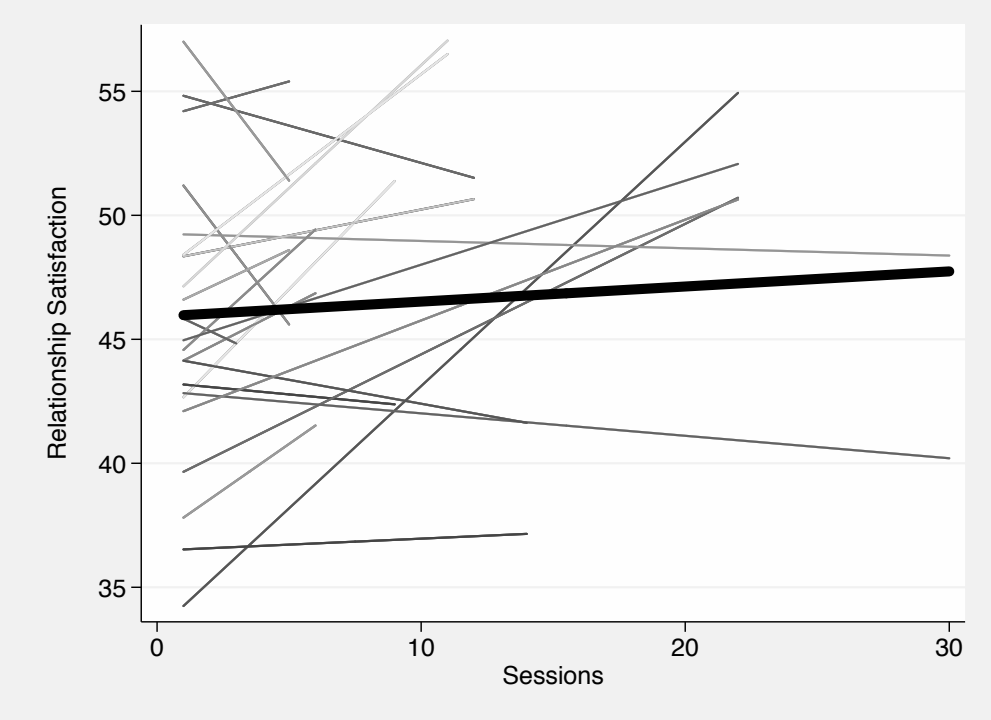

Figure 2. Average trajectory of change in relationship satisfaction.

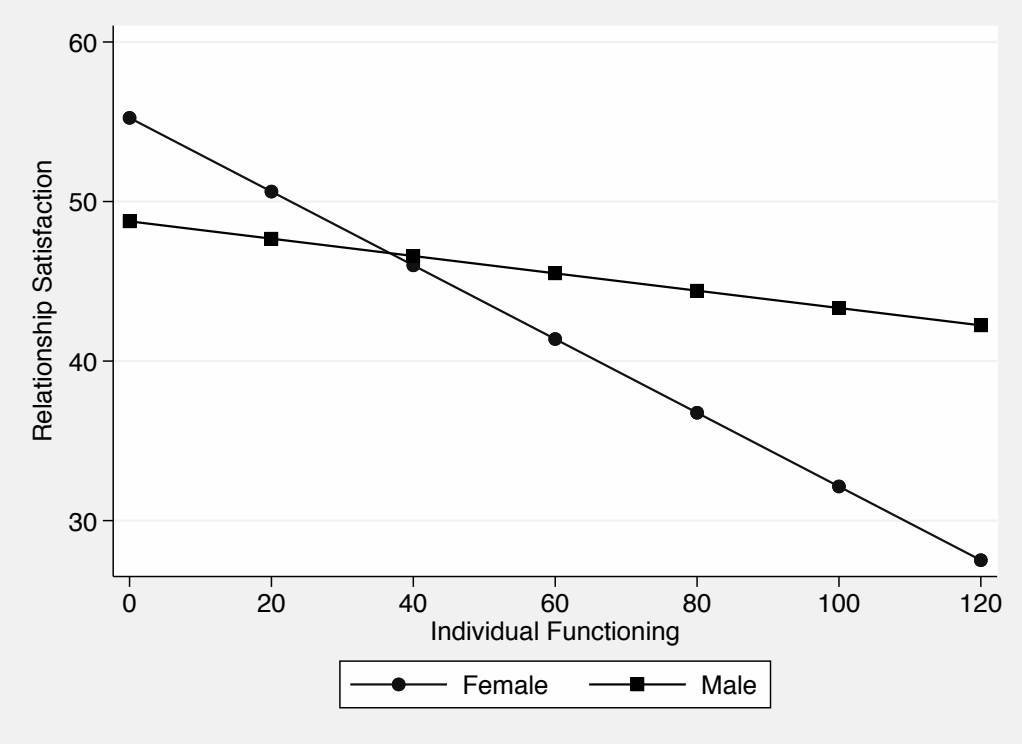

Figure 3. Gender differences in the impact of individual functioning on relationship satisfaction scores.

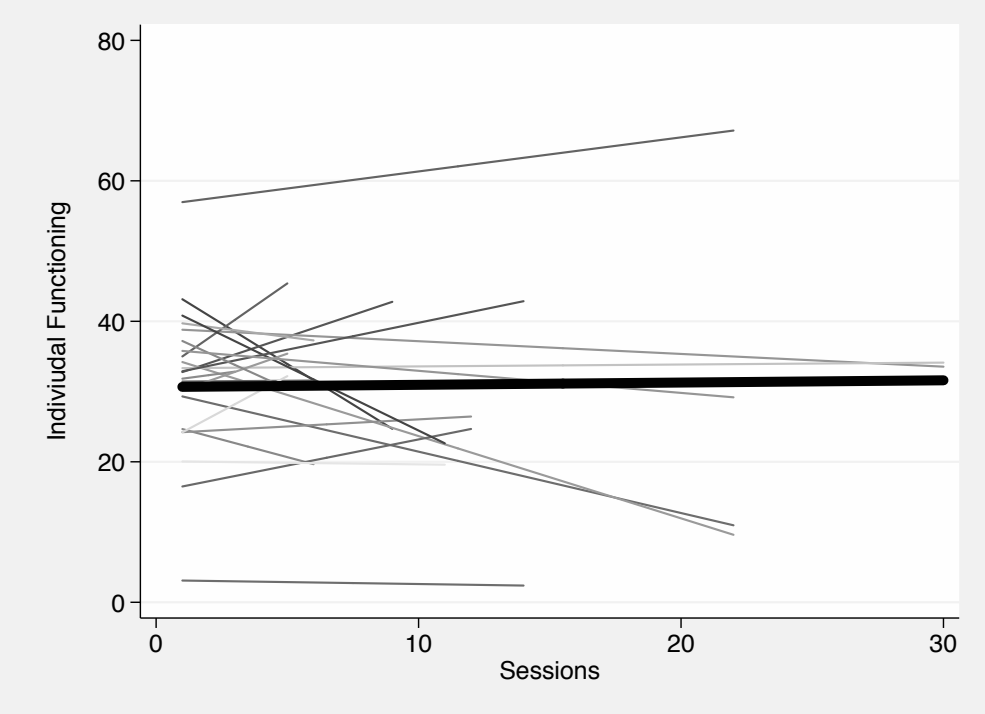

Figure 4. Average trajectory of change in individual functioning.

Appendix E - ListServ/Email Recruitment of EFT Therapists

Dear EFT therapist,

While Emotionally Focused Therapy (EFT) has solid empirical support, data are needed about its effectiveness in every day practice. You are invited to participate in this naturalistic study of the effectiveness of EFT. We hope you will join other interested practitioners in assessing the effectiveness of EFT in clinical settings.

Your help will involve the following steps:

1. Sign a Letter of Support on your business letterhead indicating you want to be involved in the study. A sample letter will be provided.
2. Complete a brief demographic questionnaire about yourself, your training, and your couples counseling experience.
3. Provide measurement for the study for 2 to 5 couples using the Revised Dyadic Adjustment Scale, the Couples Therapy Alliance Scale, and the Outcome Questionnaire-45.2.

We are seeking therapists at ALL LEVELS OF TRAINING. Whether you feel brand new or well seasoned in using EFT, please consider participating if one of these levels applies:

- I have completed an EFT Externship
- I have completed Core Skills Training
- I am a Certified EFT Therapist
- I am a Certified EFT Supervisor
- I am an EFT Trainer

If you are interested, please respond to ammitchell@bsu.edu or call/text Amy at 317-473-1744. With your expressed interest Amy will contact you and provide more detailed information.

It is our hope that this research will support your work as an EFT therapist and provide valuable information for future EFT therapists. Thank you so much for your time, your generosity, and your interest in advancing the study of EFT.

PRINCIPAL INVESTIGATOR
Amy M. Mitchell, M.A.

Ball State University
Department of Counseling Psychology and Guidance Services
Muncie, IN 47306
Phone: 317-473-1744
Email: ammitchell@bsu.edu

FACULTY ADVISOR
Paul Spengler, Ph.D., H.S.P.P.
Ball State University
Department of Counseling Psychology and Guidance Services
Muncie, IN 47306
Phone: 765-285-8040
Email: pspengle@bsu.edu

Appendix F - Letter of Support Template for Therapists

This must be on letterhead.

Date: Month, Day, 2015

Amy M. Mitchell, M.A.
Counseling Psychology and Guidance Services
Teachers College (TC), Room 605
Ball State University
Muncie, IN 47306

Dear Amy Mitchell,

You have permission to collect data for the study "Clinical Effectiveness of Emotionally Focused Therapy (EFT) for Couples" at _____ (Name of Institution). Specifically, you have permission to collect client and therapist demographic information, and the results of the following assessments: the Couples Therapy Alliance Scale, the Revised Dyadic Adjustment Scale, and the Outcome Questionnaire 45.2 to be confidentially used as part of the research project.

Signed,

Title

Appendix G - Informed Consent for Therapists

TITLE OF THE STUDY
Clinical Effectiveness of Emotionally Focused Therapy for Couples

PRINCIPAL INVESTIGATOR
Amy M. Mitchell, M.A.
Ball State University
Department of Counseling Psychology and Guidance Services
Phone: 317-473-1744
Email: ammitchell@bsu.edu

FACULTY ADVISOR
Paul Spengler, Ph.D., H.S.P.P.
Ball State University
Department of Counseling Psychology and Guidance Services
Phone: 765-285-8040
Email: pspengle@bsu.edu

DESCRIPTION OF THE RESEARCH
The main purpose of this study is to understand the benefits of Emotionally Focused Therapy for Couples as it is used in every day practice.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?
Information will be kept confidential and secure. Method of transmission of data will be selected by you. Information can be sent via mail, secure fax, or email. All electronic data will be kept on a locked computer and all documents will be password protected. All data collected in hard copy form will be scanned into electronic form, password protected, and the original will be shredded. All data collected will be combined for statistical analyses and will not be associated with participants names in the published results.

WHAT WILL MY PARTICIPATION INVOLVE?
Your participation in this study is completely voluntary.

If you decide to participate, you will complete a few brief demographic questions about yourself and your psychotherapy training. Then you will be asked to share a letter of information about this study with the next five couples seeking treatment at your site. If they elect to participate, you will allow them to sign the Client Informed Consent document and complete a demographic data sheet. You will then support your participating clients in completing three measures as outlined in the "Letter of Information for Therapists" document.

ARE THERE ANY RISKS TO ME?
Explaining the study and gathering the information from your clients may take up about 10-15 minutes of your time.

ARE THERE ANY BENEFITS TO ME?

By participating in this study you may gain experience in assessing the outcomes of your personal psychotherapy practice. Indirectly, the counseling field and future clients will benefit from the information gained through this study. Information gained from this study will provide a better understanding of how you and your clients experience the process of EFT in your daily practice.

WHOM SHOULD I CONTACT IF I HAVE QUESTIONS
You may ask questions about the research at any time by contacting Amy Mitchell at the telephone number or email address given above.

For questions about your rights as a research subject, please contact Director, Office of Research Integrity, Ball State University, Muncie, IN 47306, (765) 285-5052, irb@bsu.edu.

If you wish to participate, sign and date this document, and return it to the Principal Investigator.

By signing you acknowledge that:
1. You are attempting to use EFT with the couples to whom questionnaires will be given.
2. You have read and understand the aforementioned information.
3. Your participation is voluntary and confidential.

_____ _____

Signature Date

Appendix H – Demographic Questionnaire for Therapists

Basic Demographics

1. Age (in years) _____

2. Gender _____

3. Race/Ethnicity
   a. African American/Black
   b. Asian/Pacific Islander
   c. Caucasian/white
   d. Hispanic/Latino(a)
   e. Native American Indian
   f. Other, please specify: _____

Training/Experience Information

4. Please select highest degree obtained:
   a. MA
   b. MEd
   c. MS
   d. Ph.ED.
   e. Ph.D.
   f. Psy.D.
   g. Other, please specify: _____

5. Please indicate licensure:
   a. LMHC
   b. LMFT
   c. LPC
   d. LCSW
   e. School
   f. HSPP
   e. Other, please specify: _____

6. Years providing therapy (including training) _____

7. EFT Training Level, select one:
   a. I have completed an EFT Externship
   b. I have completed Core Skills Training
   c. I am a Certified EFT Therapist

d. I am a Certified EFT Supervisor
e. I am an EFT Trainer

8. Years practicing EFT_____

Please estimate, over the last two months, on average how many hours per week you have spent:

9. In supervision/consultation, EFT specific _____
10. In supervision/consultation, general _____
11. Listening to/watching your own recorded sessions _____
12. Reading, reviewing or watching EFT training materials _____

Resource Information

13. Please circle how many minutes do you spend in a typical couple's session?
30 45 50 60 90 Other: _____

14. Please indicate, on average, the amount in dollars you charge for a couple's session? _____

Appendix I - Letter of Recruitment for Clients

Dear Couple,

This letter is an invitation to participate in a very important research project, that is expected to benefit you and future couples seeking therapy. This study is gathering data about how Emotionally Focused Couples Therapy (EFT) works in every day settings, rather than just in laboratories. Your couples' therapist plans to use EFT to help your relationship.

Before explaining the study, we want to congratulate you on seeking support for your relationship! That is an important step – one we hope you and other couples will continue to find helpful. While you are attending therapy, I wonder if you would be willing to complete just a couple of questionnaires?

What this involves is completing the Revised Dyadic Adjustment Scale (RDAS) and the Outcome Questionnaire 45.2 (OQ 45.2) each time you come in to see your therapist. The RDAS is just 14 questions about how you and your partner get along. The OQ 45.2 asks 45 very brief questions about how you are doing individually. Completing both of these might take you about 5-8 minutes each time. Also after your 3rd session, you will answer some questions about how comfortable you feel with your therapist. That will also only take 2-3 minutes. Overall, answering these questions is expected to take up a small amount of your time, and will provide a lot of helpful information about how your treatment is going.

Deciding to participate in this study is *completely voluntary.* If you decline to participate, it will not have any impact on your therapy or the services you receive. If you do decide to participate – welcome! Please ask your therapist to give you the Client Informed Consent, which contains more information about the study and asks you to provide your signature as a way to confirm your interesting in participating. *At any time if you become uncomfortable with participating you may withdraw without any negative consequence.*

Thank you for your consideration and possible participation in this study about how therapy works for couples! I am available to answer any questions you have about this study. Please do not hesitate to contact me via telephone (317-473-1744) or email (ammitchell@bsu.edu).

Amy M. Mitchell, M.A.
Principal Investigator
ammitchell@bsu.edu
Ball State University
Muncie, Indiana

Paul Spengler, Ph.D.
Faculty Advisor
pspengle@bsu.edu
Ball State University
Muncie, Indiana

Appendix J – Therapist Task Flow Chart

Step 1 – Enroll in the Study

- Email Amy Mitchell at ammitchell@bsu.edu or call at 317-473-1744.
- Complete and send these documents
  - A Letter of Support on company letterhead
  - Therapist Informed Consent Document
  - Therapist Demographic Questionnaire

Step 2 – Enroll Clients in the Study

- Give your next **5 couples** a Letter of Recruitment for the client and ask for them to participate in the research study
- For clients opting to participate complete and return
  - Client Informed Consent Document (client signs)
  - Client Demographic Questionnaire (client completes)

Step 3 – Give These Measures in that session and Subsequent Sessions

- THESE MEAUSRES WILL BE GIVEN EVERY SESSION
  - Revised Dyadic Adjustment Scale (RDAS)
  - Outcome Questionnaire 30.2 (OQ 30.2)

- THIS MEASURE WILL BE GIVEN FOLLOWING THE 3rd **COMBINED** SESSION
  - Couples Therapy Alliance Scale

Step 4 – Complete Termination Document

- Complete Termination Document
- Follow up with Amy Mitchell at ammitchell@bsu.edu or call at 317-473-1744 with any questions and to ensure submission of all data is completed.

Appendix K – Informed Consent for Clients

TITLE OF THE STUDY
Clinical Effectiveness of Emotionally Focused Therapy for Couples

PRINCIPAL INVESTIGATOR
Amy M. Mitchell, M.A.
Ball State University
Department of Counseling Psychology and Guidance Services
Phone: 317-473-1744
Email: ammitchell@bsu.edu

FACULTY ADVISOR
Paul Spengler, Ph.D., H.S.P.P.
Ball State University
Department of Counseling Psychology and Guidance Services
Phone: 765-285-8040
Email: pspengle@bsu.edu

DESCRIPTION OF THE RESEARCH
The main purpose of this study is to understand the benefits of Emotionally Focused Therapy for Couples as it is used in every day practice.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?
Your information will be kept confidential and secure. Your data may be transmitted via mail, secure fax, or email. All electronic data will be kept on a locked computer and all documents will be password protected. All data collected in hard copy form will be scanned into electronic form, password protected, and the original will be shredded. All data collected will combined for statistical analyses and will not be associated with your name when reported.

WHAT WILL MY PARTICIPATION INVOLVE?
Your participation in this study is completely voluntary.

If you decide to participate, you will complete some basic demographic information to be sent to the principal investigator. You will be asked to complete The Couple Therapy Alliance Scale one time, which may take about 2-5 minutes of your time. Each time you see your therapist you will be asked to compete these items: Outcome Questionnaire 45.2 and the Revised Dyadic Adjustment Scale, which may take about 3-8 minutes of your time.

ARE THERE ANY RISKS TO ME?
There are no specific risks of participating in this study.

ARE THERE ANY BENEFITS TO ME?
There are multiple benefits to participating in this study. Completing these questionnaires will allow your therapist to see whether your participation in counseling is benefitting you. The information gathered will help researchers and therapists best understand how couples relationships can improve in therapy. Your participation will benefit couples in the future that are

seeking therapy.

WHOM SHOULD I CONTACT IF I HAVE QUESTIONS
You may ask questions about the research at any time by contacting Amy Mitchell at the telephone number or email address given above.

For questions about your rights as a research subject, please contact Director, Office of Research Integrity, Ball State University, Muncie, IN 47306, (765) 285-5052, irb@bsu.edu.

If you wish to participate, please sign in the space provide below.

By signing below you acknowledge that:
1. You have read and understand the information.
2. Your participation is voluntary and confidential.

_____ _____

Name Date

Appendix L – Demographic Questionnaire for Clients

Basic Demographics

1. Age (in years) _____

2. Gender _____

3. Please indicate your Race/Ethnicity
    a. African American/Black
    b. Asian/Pacific Islander
    c. Caucasian/white
    d. Hispanic/Latino(a)
    e. Native American Indian
    f. Other, please specify: _____

4. Do you consider yourself to be:
    a. Heterosexual or straight
    b. Gay or lesbian
    c. Bisexual

5. Estimated household annual income (in dollars)_____

6. Years of education (including k-12th)_____

Relationship Information

7. Years in Current Relationship _____

8. Status of Relationship (e.g., married, engaged, co-habitating)_____

9. Number of prior committed relationships/marriages _____

10. Number of children with current partner _____

11. Number of children total _____

12. Special needs of children (list) _____

13. Number of people living in the household _____

Appendix M – Revised Dyadic Adjustment Scale (RDAS)

Name_____ **Date**_____ **Session #**_____

Most people have disagreements in their relationships. Please indicate below the extent of agreement or disagreement between you and your partner for each item.

	Always Agree (5)	Almost Always Agree (4)	Occasionally Agree (3)	Frequently Disagree (2)	Almost Always Disagree (1)	Always Disagree (0)
1. Religious matters						
2. Demonstrations of affection						
3. Making major decisions						
4. Sex relations						
5. Conventionality (correct or proper behavior)						
6. Career decisions						

	All the Time (0)	Most of the time (1)	More often than not (2)	Occasionally (3)	Rarely (4)	Never (5)
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?						
8. How often do you and your partner quarrel?						
9. Do you ever regret that you married (or lived together)?						
10. How often do you and your mate "get on each other's nerves"?						

	Every Day (4)	Almost Every Day (3)	Occasionally (2)	Rarely (1)	Never (0)
11. Do you and your mate engage in outside interests together?					

How often would you say the following events occur between you and your mate?

	Never (0)	Less than once a month (1)	Once or twice a month (2)	Once or twice a week (3)	Once a day (4)	More often (5)
12. Have a stimulating exchange of ideas						
13. Work together on a project						
14. Calmly discuss something						

Appendix N – Outcome Questionnaire 30.2 (OQ-30.2)

Outcome Questionnaire **Name:** _____ **ID:** _____ **Date:** ___/___/_____

OQ®-30.2 English Adult Self Report

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and fill the circle completely under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

Please mark your answers like this: ○ ● ○

Not like this: ✖ ✔ ●

	Never	Rarely	Sometimes	Frequently	Almost Always
1. I have trouble falling asleep or staying asleep.	○	○	○	○	○
2. I feel no interest in things.	○	○	○	○	○
3. I feel stressed at work, school or other daily activities.	○	○	○	○	○
4. I blame myself for things.	○	○	○	○	○
5. I am satisfied with my life.	○	○	○	○	○
6. I feel irritated.	○	○	○	○	○
7. I have thoughts of ending my life.	○	○	○	○	○
8. I feel weak.	○	○	○	○	○
9. I find my work/school or other daily activities satisfying.	○	○	○	○	○
10. I feel fearful.	○	○	○	○	○
11. I use alcohol or a drug to get going in the morning.	○	○	○	○	○
12. I feel worthless.	○	○	○	○	○
13. I am concerned about family troubles.	○	○	○	○	○
14. I feel lonely.	○	○	○	○	○
15. I have frequent arguments.	○	○	○	○	○
16. I have difficulty concentrating.	○	○	○	○	○
17. I feel hopeless about the future.	○	○	○	○	○
18. I am a happy person.	○	○	○	○	○
19. Disturbing thoughts come into my mind that I cannot get rid of.	○	○	○	○	○
20. People criticize my drinking (or drug use). (If not applicable, mark "never".)	○	○	○	○	○
21. I have an upset stomach.	○	○	○	○	○
22. I am not working/studying as well as I used to.	○	○	○	○	○
23. I have trouble getting along with friends and close acquaintances.	○	○	○	○	○
24. I have trouble at work/school or other daily activities because of drinking or drug use. (If not applicable, mark "never".)	○	○	○	○	○
25. I feel that something bad is going to happen.	○	○	○	○	○
26. I feel nervous.	○	○	○	○	○
27. I feel that I am not doing well at work/school or in other daily activities.	○	○	○	○	○
28. I feel something is wrong with my mind.	○	○	○	○	○
29. I feel blue.	○	○	○	○	○
30. I am satisfied with my relationships with others.	○	○	○	○	○

Developed by:
Michael J. Lambert, Ph.D.
and
Gary M. Burlingame, Ph.D.

For More Information Contact:

OQ Measures, LLC
P.O. Box 521647
Salt Lake City, UT 84152

Toll-Free USA:
1-888-MII-SCORE
(1-888-647-2673)

Phone: (801) 649-4392
Fax: (801) 747-6900

Email:
INFO@OQMEASURES.COM

Website:
WWW.OQMEASURES.COM

OQ30ENG Version 1.0
1/05/2007

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Appendix O – Couples Therapy Alliance Scale (CTAS)

Questions about your Therapy – Couples Therapy

The following questions refer to your feelings and thoughts about your therapy right now. Please rate how much you agree or disagree with each statement.

My partner and I do *not* accept each other in this therapy.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

My partner and I are in agreement about our goals for this therapy.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

My partner and I are *not* pleased with the things that each of us does in this therapy.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

The following questions refer to your feelings and thoughts about your therapy and your therapist, _____, right now. Please rate how much you agree or disagree with each statement.

The therapist cares about me as a person.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

The therapist understands my goals in this therapy.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

My therapist and I are in agreement about the way the therapy is being conducted.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

The therapist does *not* understand the relationship between my partner and myself.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

The therapist cares about the relationship between my partner and myself.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

The therapist does *not* understand the goals that my partner and I have for ourselves as a couple in this therapy.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

My partner feels accepted by the therapist.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

My partner and the therapist are in agreement about the way the therapy is being conducted.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

The therapist understands my partner's goal for this therapy.

☐ Completely disagree ☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Completely agree

Appendix P – Termination Document

The following questions request brief information about a couple from you collected practice data. Please provide your best clinical estimate for each answer.

Individual Information

Spouse Code: _____

Please complete the following information for the individual who's code you entered above.

1a. Severe Illness/Disability _____

_____

2a. DSM Diagnosis (if any) _____

_____

3a. Childhood/prior relationship traumas _____

_____

_____

Spouse Code: _____

Please complete the following information for the individual who's code you entered above.

1b. Severe Illness/Disability _____

_____

2b. DSM Diagnosis (if any) _____

_____

3b. Childhood/prior relationship traumas _____

_____

_____

Relationship Information

1. Attachment injuries present in current relationship _____

_____

2. Type of Injury _____

_____

3. Estimated number of months since the injury started _____

4. Estimated number of months the injury lasted _____

Treatment Information

1. Total Number of Sessions Completed _____

2. Typical length of Sessions in Minutes _____

3. Select your best estimate of the last *completed* stage of the EFT model at termination

- ☐ Stage 1: Cycle De-escalation
- ☐ Stage 2: Restructuring Positions
- ☐ Stage 3: Consolidation

Please note if you experienced significant blocks to the completion of any stages: _____

_____

_____

_____

_____

4. Please check the option that most applies to this case:

- ☐ The couple completed treatment successfully.
- ☐ The couple terminated treatment prior to successful completion.
- ☐ The couple dropped out of treatment without terminating.

5. Reason for Termination _____

_____

_____

Appendix Q – IRB Letter

BALL STATE UNIVERSITY

Office of Research Integrity
Institutional Review Board (IRB)
2000 University Avenue
Muncie, IN 47306-0155
Phone: 765-285-5070

DATE:	March 31, 2016
TO:	Amy Mitchell, MA
FROM:	Ball State University IRB
RE:	IRB protocol # 755789-2
TITLE:	Clinical Effectiveness of Emotionally Focused Therapy (EFT) for Couples
SUBMISSION TYPE:	Revision
ACTION:	APPROVED
DECISION DATE:	March 30, 2016
EXPIRATION DATE:	March 30, 2018
REVIEW TYPE:	**Expedited**: This protocol had been determined by the board to meet the definition of minimal risk.

The Institutional Review Board has approved your Revision for the above protocol, effective March 30, 2016 through March 30, 2018. All research under this protocol must be conducted in accordance with the approved submission and in accordance with the principles of the Belmont Report.

Review Type:

	Category 1: Clinical studies of drugs and medical devices
	Category 2: Collection of blood samples by Finger stick, Heel stick, Ear stick, or Venipuncture
	Category 3: Prospective collection of biological specimens for research purposes by noninvasive means
	Category 4: Collection of data through Non-Invasive Procedures Routinely Employed in Clinical Practice, excluding procedures involving Material (Data, Documents, Records, or Specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis)
	Category 5: Research involving materials that have been collected or will be collected solely for non-research purposes.
	Category 6: Collection of Data from Voice, Video, Digital, or Image Recordings Made for Research Purposes

X	**Category 7**: Research on Individual or Group Characteristics or Behavior or Research Employing Survey, Interview Oral History, Focus Group, Program Evaluation, Human Factors, Evaluation, or Quality Assurance Methodologies
	Category 8: Continuing review of research previously approved by the convened IRB
	Category 9: Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories 2-8 do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and not additional risks have been identified.

Editorial Notes:

1. APPROVE

As a reminder, it is the responsibility of the P.I. and/or faculty sponsor to inform the IRB in a timely manner:

- when the project is completed,
- if the project is to be continued beyond the approved end date,
- if the project is to be modified,
- if the project encounters problems, or
- if the project is discontinued.

Any of the above notifications must be addressed in writing and submitted electronically to the IRB (http://www.bsu.edu/irb). Please reference the IRB protocol number given above in any communication to the IRB regarding this project. Be sure to allow sufficient time for review and approval of requests for modification or continuation. If you have questions, please contact Jennifer Weaver at 765-285-5034 or jmweaver@bsu.edu.

In the case of an adverse event and/or unanticipated problem, you will need to submit written documentation of the event to IRBNet under this protocol number and you will need to directly notify the Office of Research Integrity (http://www.bsu.edu/irb) **within 5 business days**. If you have questions, please contact (ORI Staff).

Please note that all research records must be retained for a minimum of three years after the completion of the project or as required under Federal and/or State regulations (ex. HIPAA, FERPA, etc.). Additional requirements may apply.

Office of Research Integrity
Institutional Review Board (IRB)
2000 University Avenue
Muncie, IN 47306-0155
Phone: 765-285-5070

DATE:	March 29, 2018
TO:	Amy Mitchell, MA
FROM:	Ball State University IRB
RE:	IRB protocol # 755789-3
TITLE:	Clinical Effectiveness of Emotionally Focused Therapy (EFT) for Couples
SUBMISSION TYPE:	Continuing Review/Progress Report
ACTION:	APPROVED
DECISION DATE:	March 28, 2018
EXPIRATION DATE:	March 27, 2020
REVIEW TYPE:	**Expedited**: This protocol had been determined by the board to meet the definition of minimal risk.

The Institutional Review Board has approved your Continuing Review/Progress Report for the above protocol, effective March 28, 2018 through March 27, 2020. All research under this protocol must be conducted in accordance with the approved submission and in accordance with the principles of the Belmont Report.

Review Type:

	Category 1: Clinical studies of drugs and medical devices
	Category 2: Collection of blood samples by Finger stick, Heel stick, Ear stick, or Venipuncture
	Category 3: Prospective collection of biological specimens for research purposes by noninvasive means
	Category 4: Collection of data through Non-Invasive Procedures Routinely Employed in Clinical Practice, excluding procedures involving Material (Data, Documents, Records, or Specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis)
	Category 5: Research involving materials that have been collected or will be collected solely for non-research purposes.
	Category 6: Collection of Data from Voice, Video, Digital, or Image Recordings Made for Research Purposes

	Category 7: Research on Individual or Group Characteristics or Behavior or Research Employing Survey, Interview Oral History, Focus Group, Program Evaluation, Human Factors, Evaluation, or Quality Assurance Methodologies
X	**Category 8**: Continuing review of research previously approved by the convened IRB
	Category 9: Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories 2-8 do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and not additional risks have been identified.

Editorial Notes:

1. Continuing Review Approved

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Appendix R - Multilevel Modeling Equations

Unconditional Growth Model for Relationship Satisfaction with Individual Functioning as a Covariate

Level 1 (repeated measures):

$$Y_{it} = \pi_{0i} + \pi_{1i}(T_{it}) + \pi_{2i}(X_{it}) + e_{it}$$

Level 2 (individuals):

$$\pi_{0i} = \beta_{00} + r_{0i}$$

$$\pi_{1i} = \beta_{10} + r_{1i}$$

Level 3 (couples):

$$\beta_{00j} = {}_{000} + u_{00j}$$

$$\beta_{10j} = {}_{100} + u_{10j}$$

Unconditional Growth Model for Individual Functioning

Level 1 (repeated measures):

$$Y_{it} = \pi_{0i} + \pi_{1i}(T_{ti}) + e_{tij}$$

Level 2 (individuals):

$$\pi_{0ij} = \beta_{00j} + r_{0i}$$

$$\pi_{1ij} = \beta_{10j} + r_{0i}$$